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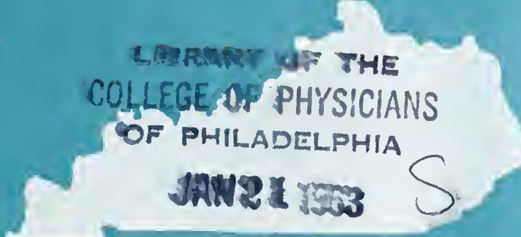

The JOURNAL *of the Kentucky State Medical Association*

KSMA INTERIM MEETING COVINGTON MARCH 7

In This Issue

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JANUARY 1963 · VOLUME 61 · NUMBER 1

in severe respiratory infections
refractory to other measures..

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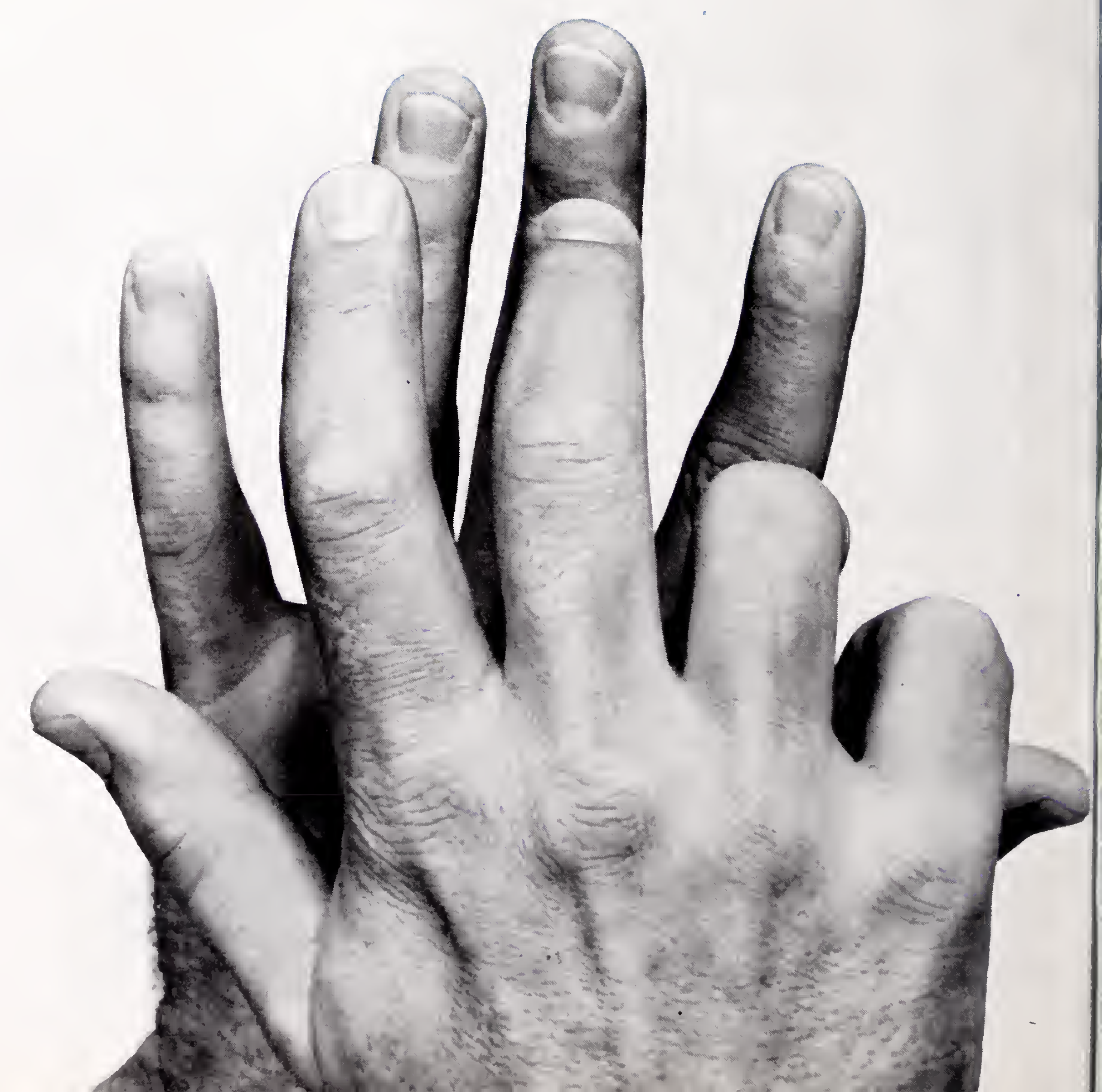

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In *Hemophilus Influenzae* Pneumonia[3,4,13,14]

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In Acute Epiglottitis[4,10,11]

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References: (1) Thacher, H. C., & Fishman, L.: *J. Maine M. A.* **52**:84, 1961. (2) Hopkins, E. W.: *Postgrad. Med.* **29**:451, 1961. (3) Hall, W. H.: *M. Clin. North America* **43**:191, 1959. (4) Krugman, S.: *Pediat. Clin. North America* **8**:1199, 1961. (5) Ede, S.; Davis, G. M., & Holmes, F. H.: *J.A.M.A.* **170**:638, 1959. (6) Wolfsohn, A. W.: *Connecticut Med.* **22**:769, 1958. (7) Calvy, G. L.: *New England J. Med.* **259**:532, 1958. (8) Hendren, W. H., III, & Haggerty, R. J.: *J.A.M.A.* **168**:6, 1958. (9) Cutts, M.: *Rhode Island M. J.* **43**:388, 1960. (10) Berman, W. E., & Holtzman, A. E.: *California Med.* **92**:339, 1960. (11) Vetto, R. R.: *J.A.M.A.* **173**:990, 1960. (12) Sia, C. C. J., & Brainard, S. C.: *Hawaii M. J.* **17**:339, 1958. (13) Rosenthal, I. M.: *GP* **17**:77 (March) 1958. (14) Gaisford, W.: *Brit. M. J.* **1**:230, 1959.

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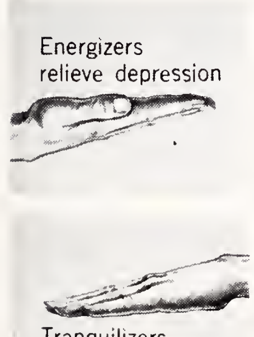

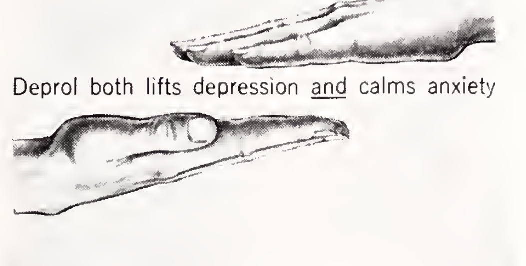

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IF A NEW YEAR IS traditionally a time for resolutions, it is also a time for reflection and thanksgiving.

As your representative, who reaps a harvest of compliments earned by the splendid accomplishments of more than 1,300 Woman's Auxiliary members, it is my privilege to make public thanks for the membership and to suggest to the membership, guideposts for reflection and resolution in the year ahead.

We would make thanksgiving for the happy accident of being doctors' wives, with its attendant privilege of serving as partners in Medicine. For not only is it our good fortune to be partners in *the most noble of arts,* but to be KSMA partners in Medicine—esteemed—and so acclaimed in Resolution K, unanimously adopted at the House of Delegates 1962 Annual Meeting.

In our reflection we would seek to distinguish the chaff from the wheat of our endeavors, remembering that the criterion of a good Auxiliary is its ability to be of real service in its own community. To this end we would, therefore, keep alert to new opportunities of service in the ever-broadening field of community health and welfare.

We would resolve to make Auxiliary membership the training ground for civic leadership and would seek ways to teach and to guide the individual members to work more wisely and effectively as responsible citizens. We would resolve to reaffirm the purpose of the Woman's Auxiliary to KSMA to conscientiously serve as partners in Medicine.

Mrs. Jo Rich, President
Woman's Auxiliary to KSMA

** This is the first of a series of guest articles to be written at the invitation of David M. Cox, M.D., president of the Kentucky State Medical Association, by the president of the Woman's Auxiliary and KSMA's vice presidents.*

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Grapefruit and other citrus fruits filled with vitamin C are valuable in the nutrition of every age group. Among the teen-agers, vitamin C is one of the two nutrients most often low in the diet. Infants, too, need generous amounts of vitamin C; and they will take it readily when it comes to them in the form of delicious orange juice.

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from Oroya fever in Peru

to lobar pneumonia in Kentucky

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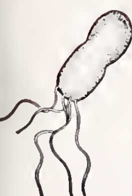

Oroya fever (Carrión's disease), prevalent only in certain valleys of the Andes, is characterized by a rapidly evolving, febrile pernicious anemia. The infecting organism is *Bartonella bacilliformis,* a gram-negative, flagellated organism, transmitted by night bites of the phlebotomus, or sand fly. The organism is unmistakably identifiable in blood films—no other human pathogen even slightly resembles it. The mortality rate of untreated Oroya fever can be as high as 40 per cent (in all probability, this was the disease which decimated Pizarro's army in the 16th century). Treatment with Terramycin produces dramatic reduction of fever and a stabilized blood count in 48 hours or less.

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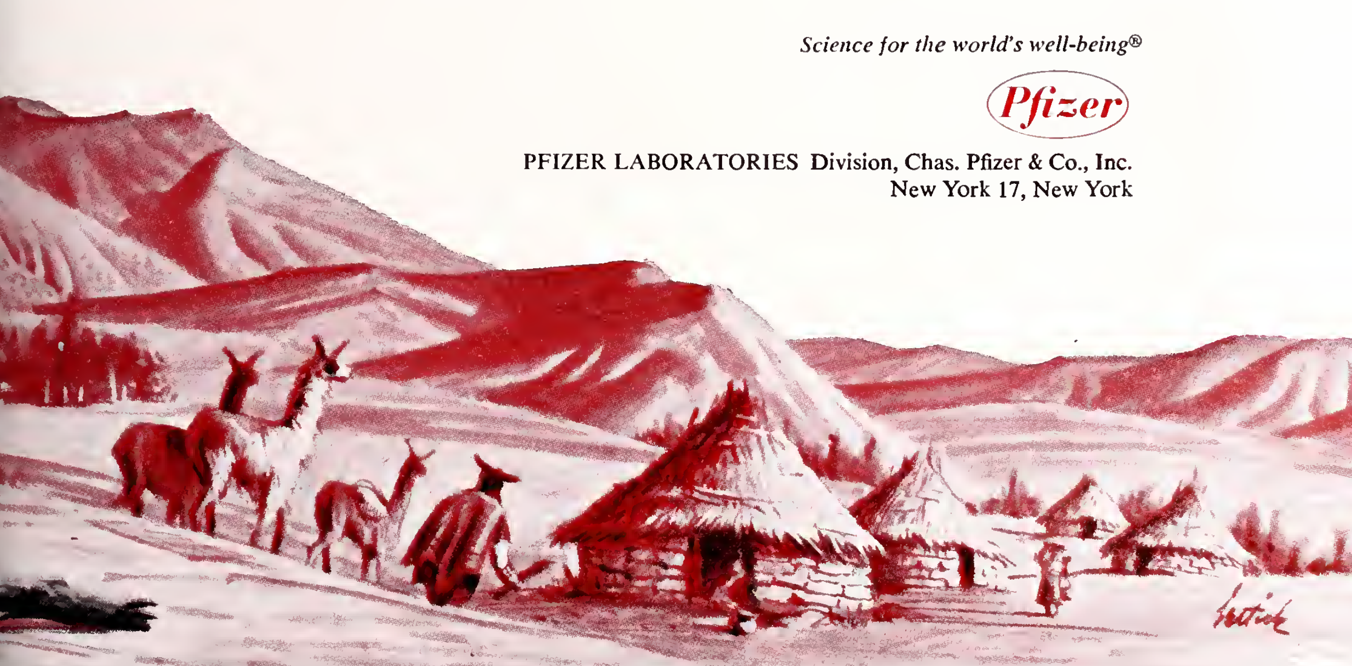

THE INSURANCE PAGE

We Must Win the Battle Against King-Anderson

AT A SPECIAL session of the House of Delegates this year the Kentucky State Medical Association approved the new Blue Shield-Blue Cross National Senior Citizens Program, which had been fully endorsed by the American Medical Association. and in which all Blue Shield plans had been urged to participate.

Dual Purpose

This program came into being with a dual purpose: First, to improve voluntary health care coverage for our aged, and second, to demonstrate to the American public that a compulsory governmental program of health care for most of our older people was not necessary, since the majority of these people could now purchase for themselves adequate prepaid health care protection at premium rates which they could afford.

It would be absurd to claim that the only reason the Administration did not succeed in pushing through its medicare program for the aged this year was the development of the National Blue Shield-Blue Cross program.

On the other hand, it would be equally foolish to state that the development of this plan played no part in the defeat of the King-Anderson legislation in the last Congress. Many Congressmen have stated to their friends in the medical profession that without the National Blue Shield-Blue Cross Senior Citizens Program, it would have been difficult to resist the pressures brought to bear on them to support the Administration's program.

In the Next Congress

There does not seem to be any doubt that President Kennedy will make a determined effort to secure enactment of a medicare program for the aged, on a Social Security basis, in the next session of Congress. If this is accomplished, it may well be the beginning of the end for our present system of medical practice.

One of the main objectives of the proponents of the Social Security approach to medicare will be to attempt to prove that voluntary mechanisms for providing health care for the aged are not adequate, and that they do not truly protect the majority of our older people against the catastrophic costs of major illness.

It will doubtless be pointed out by the press and by supporters of the Administration's medicare program that a few state medical associations did not endorse the National Blue Shield-Blue Cross program, and that a large percentage of our Kentucky physicians have not signed as participating physicians in the Kentucky Senior Citizens Program. These facts may be used as arguments to attempt to prove that many of our physicians are not interested in trying to help our elder people solve the economic problems of illness, and that it is therefore necessary for a paternalistic government to assume this responsibility. With these assumptions, of course, we do not and cannot agree.

Patients Are Assured

Those of our Kentucky physicians who have agreed to accept the allowances of the new Senior Citizens contract as payment in full for services rendered to eligible subscribers have thereby given assurance to these patients that their protection against the costs of illness will be adequate, and not merely a token protection. Against this fact, there can be no valid argument.

For these physicians who have chosen not to participate in the "full payment" agreement, there is still an inescapable responsibility to make sure that none of their patients (especially any of those over 65) can ever have a true basis for alleging that they have been charged more than a reasonable fee or more than they are able to pay. This must be true, whether these patients are covered by Blue Shield, by commercial insurance or by no type of prepayment.

Our Critics

More than ever before, our critics and the proponents of governmental medical care will be searching for examples to support their contention that the cost of medical care even with the aid of prepayment is too high for the average senior citizen to be able to afford it. If we cannot disprove this assumption, we will have lost the battle against King-Anderson legislation and perhaps also the war against socialized medicine.

W. Vinson Pierce, M.D.

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PUBLIC HEALTH PAGE

Public Health Laboratory Services*

Russell E. Teague, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

MANY PUBLIC health programs conducted by the state and local health departments require the support of certain laboratory procedures. In order to provide this laboratory support, the Kentucky State Department of Health has a Division of Laboratory Services.

The responsibilities of this division include: (1) Provision of certain diagnostic facilities for program units of the Kentucky State Department of Health, local health departments, practicing physicians and hospitals; (2) the chemical and biological examination of food, milk, water, drugs, etc.; (3) the evaluation and approval of local milk, water and syphilis serology laboratories, and (4) public health laboratory research.

Most of the diagnostic tests presently available from the Division of Laboratory Services are provided to assist in the control of communicable diseases. Physicians are encouraged to use local facilities where possible, but, in many instances, laboratory services for adequate epidemiological study and control of communicable disease may not be available locally. It is not the intention of the Division of Laboratory Services to compete with private laboratories but rather to supplement these laboratories where community health is involved.

Diagnostic procedures provided by the Division of Laboratory Services include the following:

Syphilis Serology—the VDRL slide test is performed routinely on all serum specimens submitted for syphilis serology. Other tests including the Kolmer C F, Reiter Protein C F, and TPI tests are offered on special request.

Special Serology—various serological procedures are provided including febrile agglutinations, C F tests for mycotic diseases, and heterophile agglutinations. Several fluorescent antibody procedures for rapid diagnosis are under development, and when these procedures have been adequately evaluated they will be employed as routine diagnostic tests.

Tuberculosis—laboratory procedures including direct smear, cultures and sensitivity studies on sputum and other clinical specimens are available for the diagnosis and treatment evaluation of tuberculosis.

Mycology—mycotic agents are identified from various clinical specimens by their microscopic and cultural charateristics. Reference cultures may be submitted for identification.

General Bacteriology and Parasitology—a number of laboratory tests are provided for the diagnosis of various bacteriological and parasitological diseases. These include staphylococcal phage typing, the culturing of various clinical specimens for pathogenic bacteria, the examination of stool specimens for the presence of intestinal parasites and the examination of stained smears for pathogenic bacteria or parasitic agents.

Virology—several laboratory examinations are offered for the epidemiological study and diagnosis of viral and rickettsial diseases. These procedures include the use of tissue cultures, chick embryo and mouse inoculation for virus isolation. Serological methods include the C F, hemagglutination, hemagglutination-inhibition and neutralization tests. Stained tissue smears may be of value where diagnostic inclusion bodies are found. Viral diagnostic procedures are frequently of limited value to the individual patient, as many of these tests require weeks or even months to complete, but the epidemiological significance of such tests cannot be overestimated.

Judicious use of the diagnostic services provided by the Division of Laboratory Services will enable the laboratory to give better service. Careful selection of specimens will permit the laboratory to concentrate on tests that are most applicable to the clinical condition of the patient.

Care in collection and submission of specimens cannot be overemphasized, and submission forms should be carefully completed. Special mailing containers are available through local health departments for mailing specimens to the laboratory.

A manual is being prepared by the Division of Laboratory Services which describes all diagnostic services available and provides detailed information regarding the collection and submission of specimens for examination. When this manual is completed, it will be distributed to all physicians licensed to practice medicine in Kentucky.

Requests for additional information regarding policy or services offered should be directed to the Director, Division of Laboratory Services, Kentucky State Department of Health, Frankfort, Ky.

This article was prepared by B. F. Brown, M.D., M.P.H., director, Division of Laboratory Services, Kentucky State Department of Health, Frankfort, Ky.

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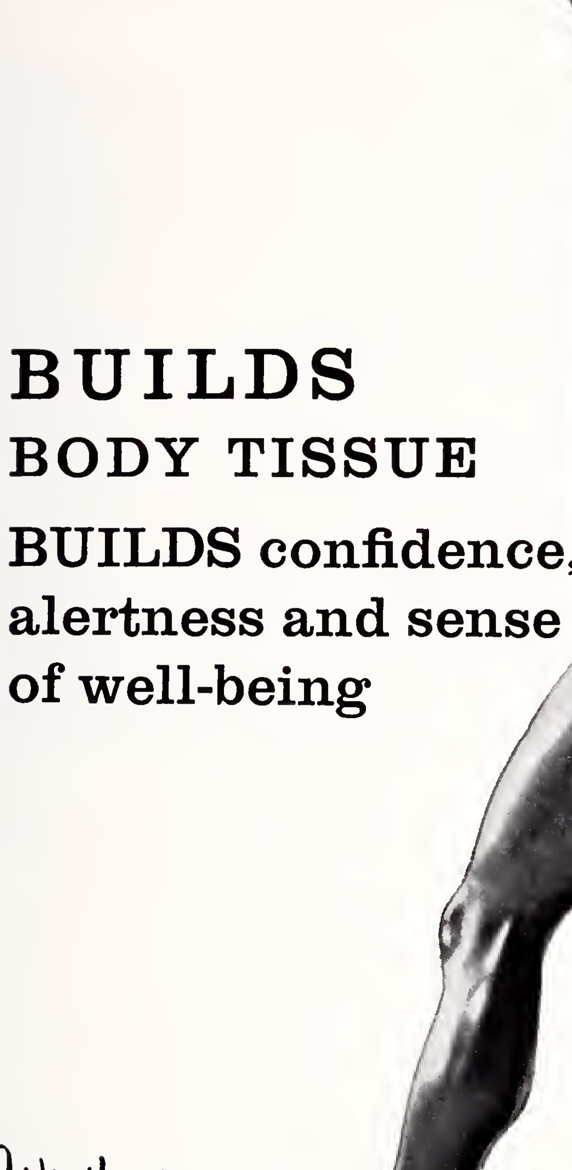

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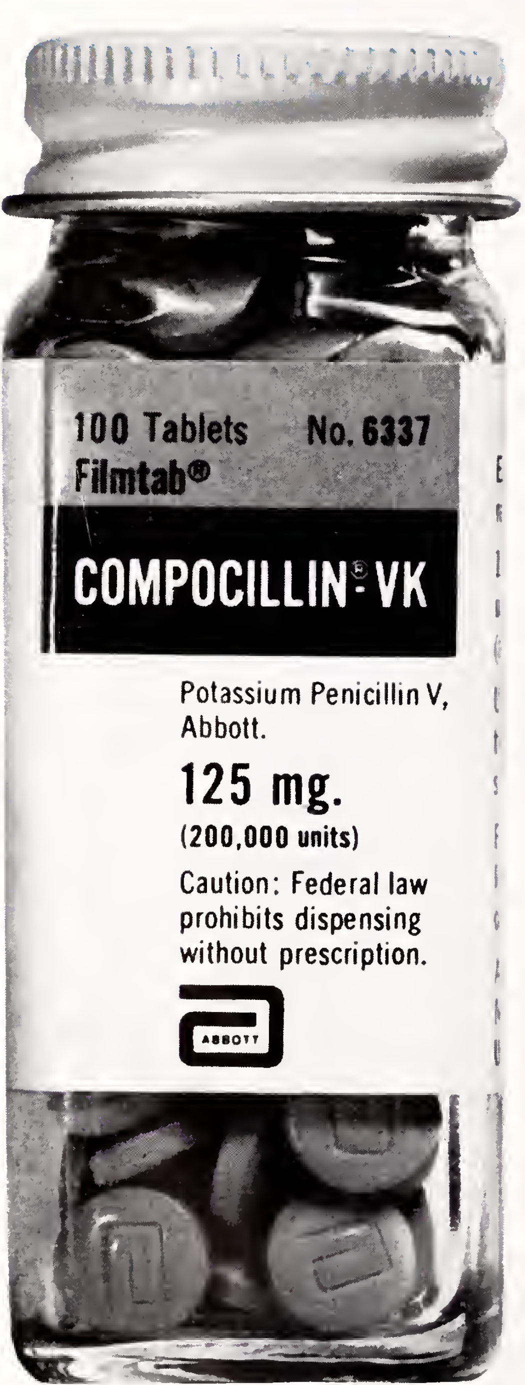
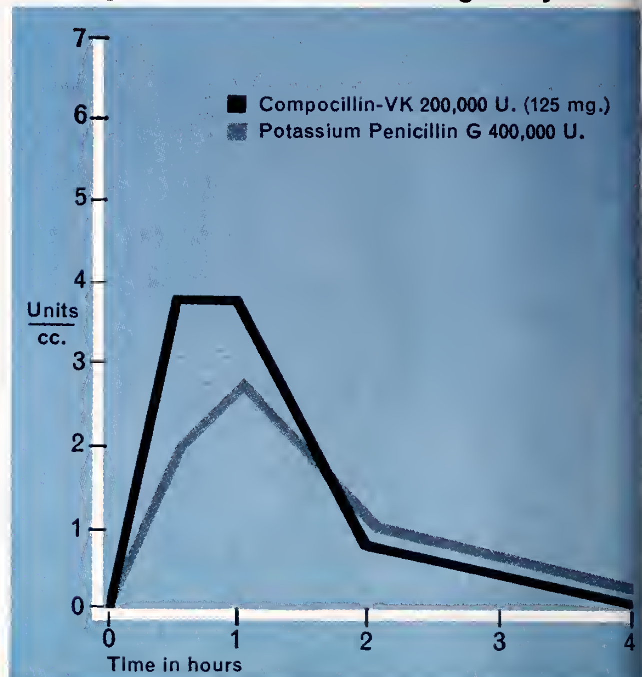


Single Oral Doses to Fasting Subjects*



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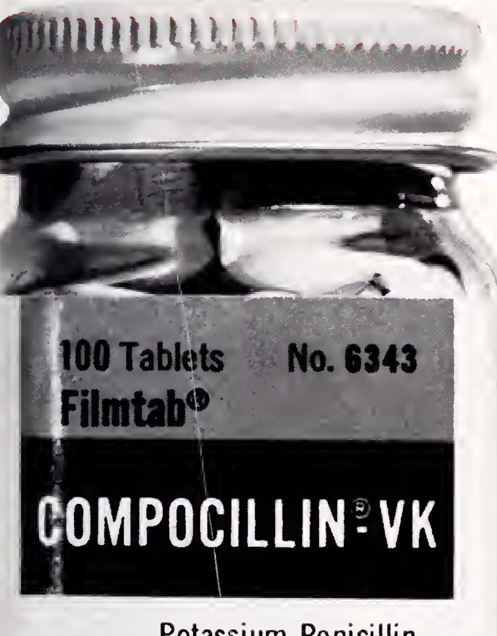

Single Oral Doses to Fasting Subjects*

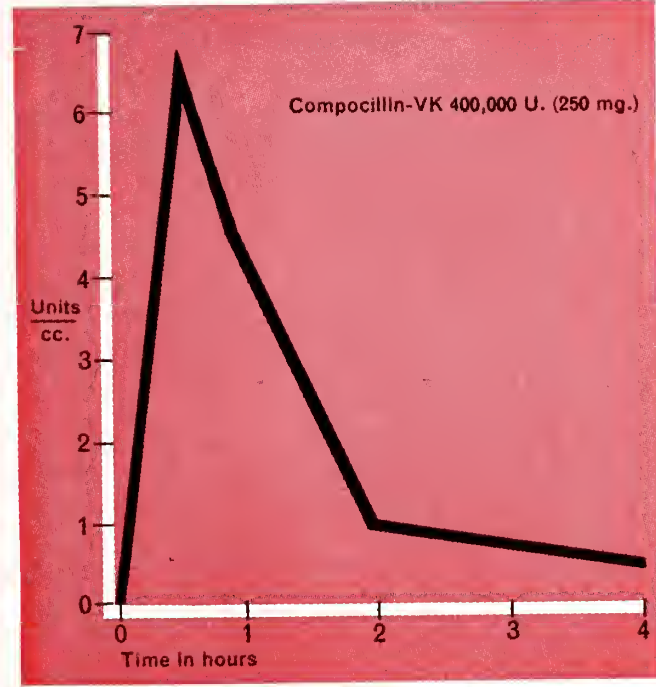

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*Chart data from two separate studies completed by the Microbiologic and Medical Departments of Abbott Laboratories.

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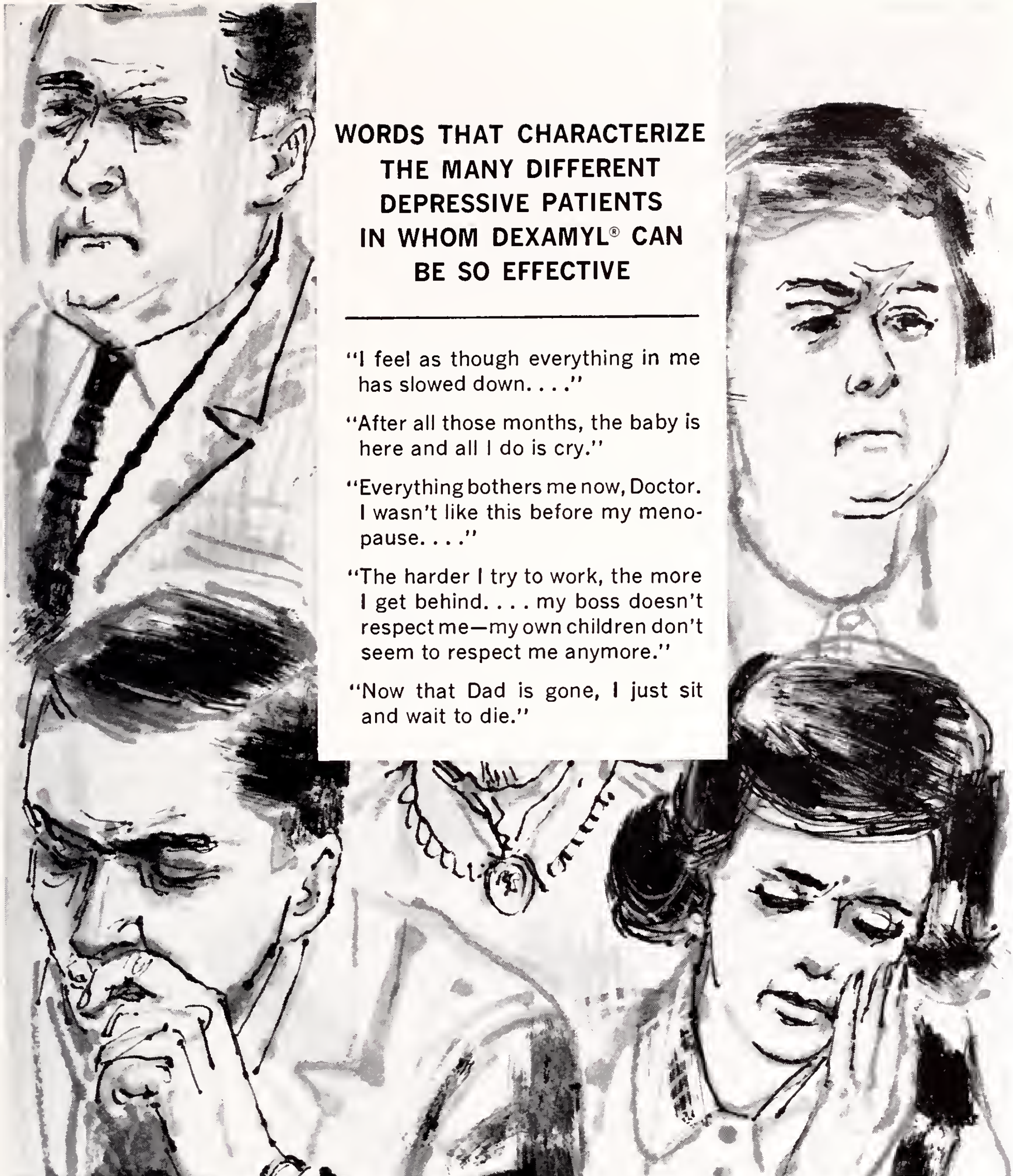

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†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

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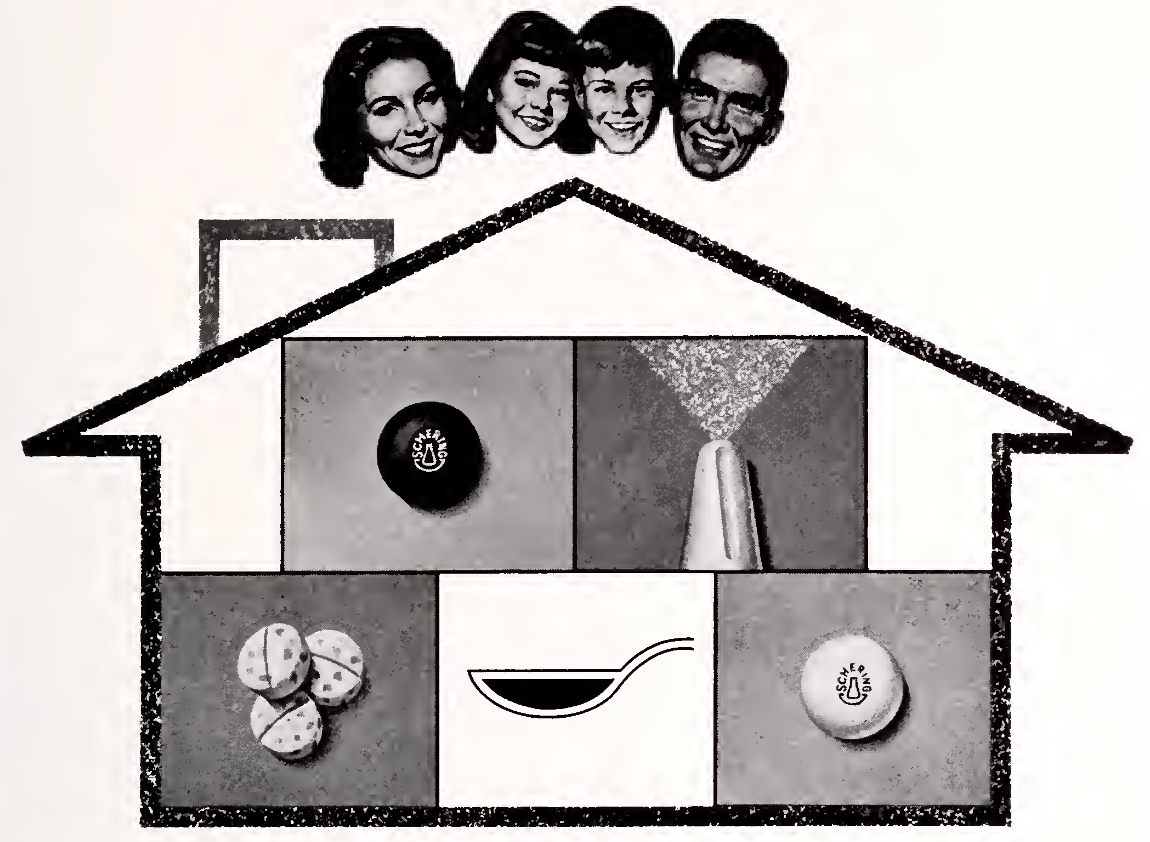

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Superstitions and Home Remedies Encountered in Present-Day Pediatric Practice in the South

WALTER T. HUGHES, M.D., F.A.A.P.*
Louisville, Ky.

Incidents of deleterious and sometimes fatal superstitious practices in modern America are described in an effort to alert the physician to another opportunity to practice preventive medicine through education.

SUPERSTITION has found no more fertile field than that of medicine. We are amazed to read of the practices of medicine men in primitive South Africa and startled at the uncanny customs of Australian aborigines and yet a six-month-old infant lying on our modern examination table with a six-month-old asafetida bag about his neck seems commonplace. Observation of southern pediatric clientele in university hospitals as well as private practice has furnished an interesting collection of superstitions and remedies which are still in use by a small portion of our present-day populace. Some are harmless and some have proved to be fatal.

Superstition is born of ignorance and fear; subsequently, these relics of unscientific medicine are adhered to by the uneducated and ignorant of the community. The following discussion refers to individuals of this particular social group and is intended to alert the physician to the opportunity for education of his patient in another phase of preventive medicine.

Assistant professor of pediatrics, University of Louisville School of Medicine, Louisville, Ky.

Navel, Gut and Nails

The newborn infant is innocent prey to many unwholesome practices. In the first week or so of life the umbilical stump, projected like a sore thumb upon the abdomen, is of great concern to parents and attendants. There seems to be an uncontrollable urge to cover it with something. Some apply soot from a stove or chimney to the navel. Occasionally, I have been frightened by seeing a liberal portion of horse manure applied to a freshly severed cord and on one occasion observed a fatal case of tetanus neonatorum initiated by a clod of equine excreta on the umbilicus. Many other potions and binders have been concocted in an attempt to cause the harmless umbilical stump to separate more rapidly.

After the umbilical cord has fallen by the wayside and the navel heals, the center of attention shifts to the gastrointestinal tract. The infant who manages two or three large, soft stools daily is indeed fortunate. Conversely, he who limits his daily excretion to only one or less is the subject of much concern regardless of the status of his health. Patent laxatives and enemas are resorted to at all too frequent intervals. I have treated a two-week-old infant with water intoxication secondary to numerous tap water enemas used in an attempt to create more than his usual one bowel movement per day.

At the other end of the fecal spectrum, purgation is frequently used as a "home remedy" for diarrhea. Many is the toddler who has received a dose of castor oil to "work him"

and rid him of his malady. Needless to say, this has speeded battalions of our modern pathogenic *E. coli* and enteroviruses to the outside world, plus copious amounts of water, sodium, chloride and potassium.

This concept of treatment is a carry-over from recommended therapy by physicians in the early part of the century. Fifty years ago Sir William Osler[1] advocated the use of castor oil or calomel for the treatment of infantile diarrhea. In severe cases hypodermic injections of ether and brandy were used. In early editions of our excellent modern pediatric textbooks[2] purgation with castor oil and calomel was recommended.

Some believe that if the infant's fingernails or toenails are cut before a certain age, usually one year, he will become ill. Most of these babies have severe facial excoriations. A similar superstition applies to cutting the hair. Many babies are not bathed until they are three months old for fear of bringing on disease.

Potions and Stinks

Respiratory tract infections are particularly susceptible to treatment with "home remedies." One of the more notorious potions is concocted by mixing several drops of kerosene or turpentine with a teaspoonful of cane sugar. This is administered orally. In some instances hydrocarbon pneumonitis has followed the frequent use of this treatment. Camphor is often placed in a bag and tied about the neck to abate chest colds. Cooked onions bandaged to the anterior chest wall are believed to "loosen up a tight chest cold." Other poultices are used in the same manner. Cloth rags are sometimes burned in the room of a child with acute tracheobronchitis, or a scorched cloth may be wrapped about the croupy neck.

The asafetida bag, worn to ward off disease of any kind, is attached to a cotton string and tied snugly about the infant's neck. It is not removed during the infantile period, and in many cases is also worn during the childhood years. Asafetida is an oleo-gum-resin obtained from rhizomes and roots of *Ferula Assafoetida* and other species of *Ferula*. Its presence is apparent when one enters the examination room, not necessarily by sight but by its pungent, persistent and offensive odor. The odor is due to a volatile oil consisting largely of a mercaptan. At times one wonders if this small stinking ball of gum with its collection of debris might not actually cause self-respecting microbes to back away from the helpless baby.

Severe cases of intertrigo have resulted from irritation of the asafetida necklace. Many parents admit that they do not believe in its reputed efficacy, but let the child wear it simply to appease the grandmother. On the other hand, I know of one seriously ill infant who was signed out of a hospital in protest to removal of a dirty asafetida bag by a nurse.

The wearing or carrying of onions, pieces of sulphur, or camphor gum is superstitiously regarded as protection against various diseases.

Powers and Bugaboos

In many communities an elder citizen is attributed with power to cure certain diseases without the aid of medicine. One such person may be able to remove verrucae and another may have the power to cure thrush. The patient presents his warty part to the practitioner who gently runs his fingers over the tumor, closes his eyes and mumbles a few phrases of jargon. The patient is then told that the wart will disappear within the next few days or week.

Infants with oral moniliasis are sometimes taken to a person who breathes into the mouth and this is believed to rid the baby of the fungus. A prerequisite for this "power" is that it must come from a man who has never seen his father. The apparent success of such practice is obviously due to the natural course of the disease.

Children are oftentimes frightened into obedience by stories of a bugaboo, a bogie or bogie man. In most instances the term bogie is used synonymously with devil. Although the origins of these words seem to be doubtful they may possibly be traced to the Celtic word *pouca*[3] meaning a mischievous phantom; or to the Old French *bugibu*, the name of a devil. What effect these stories have upon emotional stability may simply be left to the imagination.

Examples Not Novel

The aforementioned examples of superstitious practices are by no means novel to practicing physicians, especially in the southern states. They have been described simply to stimulate a somewhat more vigorous effort to explain

the fallacies of unscientific "home remedies" and superstition to the uneducated parent.

We find that this must be done with considerable tact. Scolding merely evokes rebuke. Many times the physician-parent relationship is severed by criticism of well-intended care. In most instances the "home remedy" in question has been used at one time or another with apparent success, perhaps the same success we sometimes assume from treating viral infections with antibiotics. Whether an innocuous asafetida bag has been placed about the neck or deadly tetanus spores on the umbilicus, it is done with the best intentions of a devoted attendant. Ignorance is the villain and not the parent, and ignorance can be eradicated only by education.

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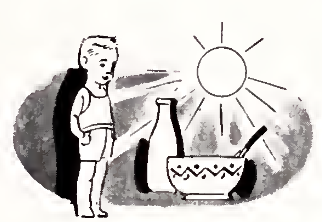

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Intramural Hematoma Causing Intestinal Obstruction

Bernard J. Schoo, M.D.

Louisville, Ky.

A precise diagnosis can be made. Signs, symptoms and diagnostic features are outlined. Prompt surgery will lessen morbidity and yield diagnostic results.

BLUNT injuries to the abdomen are a diagnostic problem. Damage to certain viscera frequently can be diagnosed before an exploratory laparotomy, but intramural hematoma of the jejunum, which follows a characteristic pattern, is rarely diagnosed before surgery. It is apparent from case reports in the literature that there is long delay between injury and surgery. The purpose of this paper is to reiterate the diagnostic signs and present a recent case.

Review of Literature

In the cases reviewed, intramural hematoma of the jejunum presents relatively the same signs and symptoms in each case. Prior to 1954, a correct preoperative diagnosis had not been recorded. In 1948, Liverud[1] reported a case involving the jejunum adjacent to the ligament of Treitz and included the only detailed x-ray description in the literature.

In 1954, Felson and Levin[2] described the typical x-ray findings of the "coil spring sign of the duodenum" which is a pathognomonic sign of this injury. In spite of this classical finding, there is no mention of it in modern x-ray textbooks. They described an 18-year-old boy who was injured playing football. He had mild abdominal pain with vomiting and surgery 10 days after his injury, but the diagnosis was made before the surgery by the x-ray department. They also described a second case of a nine-year-old boy who fell over a wire but whose history and physical findings were so compatible with appendicitis that an appendectomy was done and it wasn't until five days later that an exploratory laparotomy disclosed the intramural hematoma causing duodenal obstruction.

Lampert[3] reported a case of a 15-year-old boy kicked in the abdomen while playing basketball. He had abdominal pain and vomiting. Palpation demonstrated an oval-shaped mass, 3 x 6 cm., to the left of the umbilicus. An exploratory laparotomy five days later revealed the subserosal hemorrhage causing small bowel obstruction.

In 1956, Snider[4] described an 11-year-old boy who was hit in his abdomen while playing football. He was admitted to the hospital for vomiting and abdominal pain. "He kept his knees drawn up to his stomach." There was a firm tender mass palpated four fingers below the costal margin. Eleven days after his injury an exploratory laparotomy revealed the intramural hematoma.

In 1956, Melamed[5] reported a 19-year-old girl whose upper abdomen was injured when she was crushed against the steering wheel in an automobile accident. The x-ray findings were typical but she recuperated slowly without surgery. This case was unusual in that she was managed without surgery and was a female.

In 1957, Moody[6] described a nine-year-old boy hit in the upper abdomen by a wheelbarrow handle. Some 28 hours later he began vomiting. Thirty-six hours after the injury, he was admitted to the hospital. There was slight tenderness in the left upper quadrant but no mass was palpable. The coil spring sign was shown on the x-ray and he was operated upon seven days after his injury. Garfinkel[7] reported, in 1958, a four-year-old boy who fell against a park bench and was admitted to the hospital because of abdominal discomfort and vomiting. The abdomen was rigid but no mass was felt. Four days after his injury an exploratory laparotomy revealed an intramural hematoma.

In 1958, Swaiman[8] described a 10-year-old boy injured playing football. Because of a palpable mass in the upper abdomen seven days after his injury, an exploratory laparotomy was performed. The intestinal obstruction was due to an intramural hematoma. All of these cases did well following surgery.

Case Report

A seven-year-old boy, while sledding, ran under the seat of a large picnic table. He was knocked out of breath and was taken home immediately. Within an hour vomiting and abdominal pain began. He was taken to his pediatrician's office, who suspected a ruptured viscus and admitted him to Children's Hospital at 2 p.m. He vomited approximately six times from the time of the injury to the time he was admitted to the hospital and constantly complained of abdominal pain.

The child preferred to lie on his side with his knees drawn slightly. His pain diminished considerably and he did not appear in acute distress. Temperature — 98.6. Blood pressure — 120/60. Pulse — 88. Examination was essentially negative, except for an almost imperceptible bruise in the epigastric area. The abdomen was soft throughout, except for some moderate tenderness over the bruised area.

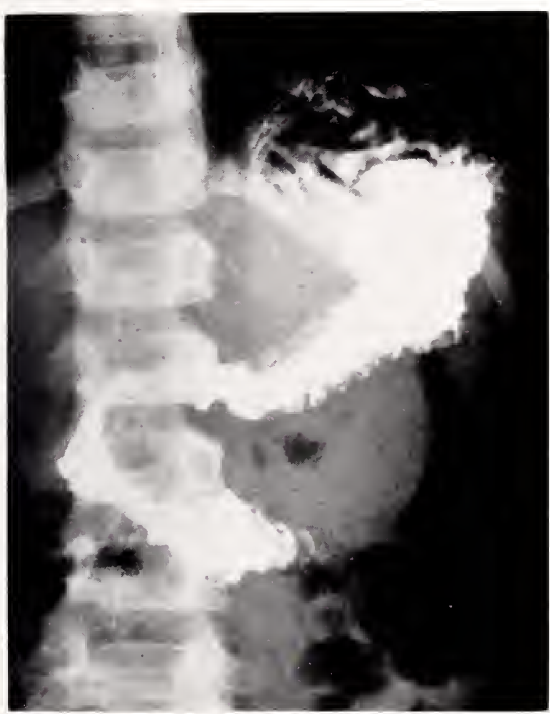

Figure 1: G.I. series. The large intramural hematoma obstructs the duodenum and displaces the adjacent loop of bowel. Large jejunal folds ("coiled spring") are outlined by air just below the opacified duodenum.

X-rays of the abdomen on admission are recorded as essentially normal. The blood count was as follows: Hgb. — 12.8 gms, WBC — 35,450, Segs — 85%, Stabs — 6%, Lymphs — 5%, Monos — 2% and Baso — 2%. Hematocrit — 40 Vol%. An injury to the pancreas and duodenum was suspected but because of his steady improvement it was decided to observe him. Throughout the night he slept well and his blood pressure, pulse and respiration remained the same. He took 500 cc. of clear liquids from the time of admission until the following morning without vomiting.

The following morning he was sitting in bed and had no complaints. The abdomen now revealed a smooth, round, slightly tender mass in the left upper quadrant approximately 4 cm. in diameter. An intramural hematoma was suspected and an upper G. I. series was done. After taking three ounces of barium, he vomited a large quantity from an obviously distended stomach. Gastric emptying was extremely slow. Films revealed a mass density protruding into the distal duodenum, with eccentricity of the barium column.

On close examination, (Figure 1), circular folds of the duodenum were noted. These were outlined with air and longer than normal. A mild indentation upon the greater curvature of the stomach was noted just opposite the region of the presumed duodenal mass. The x-ray interpretation stated these findings were compatible with a hematoma of the duodenum and the history of acute trauma would support this view.

An hour later the abdomen was opened through a left upper quadrant transverse incision. There was a small retroperitoneal hematoma along the left side of the vertebral column near the duodenum. There was a large intramural hematoma at the ligament of Treitz (Figure 2). This hematoma extended 14 cm. distal to the ligament of Treitz and contained an estimated 50 cc. of blood. The distal 5 cm. of the hematoma revealed an intussusception of the jejunum into the jejunum. The hematoma extended 2-3 cm. proximal to the ligament of Treitz. The serosa was incised longitudinally and the hematoma evacuated. No other pathology was found. (Figure 2 is on next page.)

Figure 2: The intramural hematoma extends from just proximal to the ligament of Treitz (beneath retractor) to the area of demarcation. Beyond this the mucosa intussuscepts into the jejunum.

The patient's postoperative course was uneventful and he was discharged five days later.

Conclusion

Intramural jejunal hematoma has certain diagnostic characteristics. A history of a blunt injury to the upper abdomen in a male is most common. Shortly after the injury there is moderate pain, since the hematoma stretches the serosa as it dissects between the serosa and the mucosa. The distal dissected mucosa intussuscepts into the lumen of the normal jejunum beyond, causing the pathognomonic coil spring sign seen during an upper G. I. series. Within a short time vomiting becomes profuse because the bulging mucosa obstructs the jejunum. There is little to see on inspection of the abdomen, but the patient usually is more comfortable on his side with his knees slightly flexed. Occasionally there is a palpable mass in the upper quadrant. The blood count is of little diagnostic value. An upper G. I. series confirms the diagnosis and surgical evacuation of the hematoma leads to a dramatic cure.

Summary

A short review of the literature, emphasizing the "coil spring" sign of intestinal intramural hematoma is presented along with a case report. An accurate history and earlier x-rays will shorten the time between accident and corrective surgery.

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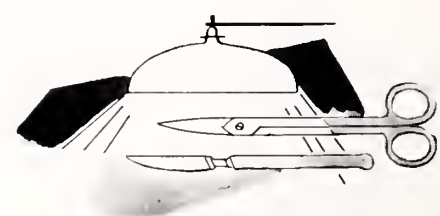

Peptic Ulcer Surgery in a Rural Community*

Charles C. Kissinger, M.D.
Henderson, Ky.

Presented here are 166 consecutive operations for peptic ulcer in a small rural hospital, often under somewhat less than ideal conditions. It is thought that the resultant statistics may suggest the true national norms.

In Kentucky the combined populations of Jefferson and Fayette counties comprise 24% of the total for the state, leaving 76% of the population in the remaining counties. Of the 141 board certified surgeons in Kentucky, 89 or 63% practice in the cities of Louisville or Lexington, leaving 52 or 37% in the remainder of the state. If one were allowed to assume that these figures are representative of the distribution of surgeons, then a new title suggests itself — namely — "How 76% of the surgery is done by 37% of the surgeons in Kentucky."

There are some fallacies in this line of reasoning but these figures do suggest that a large proportion of the surgery performed in the State of Kentucky, and probably in the United States, is performed in small communities far removed from teaching centers and that the quality of surgery rendered to this rather large segment of our population is worthy of consideration. Also it would seem only right and proper for those practicing in these communities periodically to assess their results and compare them with the accepted norms of the teaching centers.

Material

The hospital in which the cases under consideration were treated was founded as a 90-bed institution during World War II and enlarged to 140 beds in 1959. The present series of cases dates back to 1955, the date of inception of an adequate system of filing and cross-indexing of records in the hospital.

At the beginning of the series the hospital did not possess an adequate anesthesia machine, much less an anesthetist or anesthesiologist. Such assets as a blood bank, flame photometer and recovery room were not available. These deficiencies have since been remedied.

The shortage of trained nurses and other skilled ancillary personnel was, and is, a vexing problem in the postoperative care of these seriously ill patients with multiple, anchored, indwelling tubings and rapidly shifting physiological balances. Many of these patients were taken from the operating room at the completion of a procedure and handed over to the kindly but uninformed ministrations of a frightened woman dressed in white and bearing the appellation of "nurse" who had perhaps been working in an ice cream parlor only the week before. These factors are not offered as apologies but rather as facts necessary for proper evaluation of the resultant statistics. It is also suggested that the institution under consideration is not unique.

145 Patients

The series is composed of 145 patients who had a total of 166 operations. All but seven of these operations were performed by three surgeons practicing in the community. In conformity with most large series, it is obvious that serious peptic ulcer diathesis is a disease of the middle-aged white male. Out of a total of 145 patients, 112 were white males and 26 were white females. There were seven colored males and no colored females. The percentage of the population which is colored is much larger than the 4.8% found in this series. The youngest was 23, the oldest was 85 and the average was was 48.3. There were 13 deaths, giving a mortality rate of 8.9%.

The indications for surgery, in order of prevalence, were intractability, perforation, hemorrhage, obstruction, suspicion of malignancy and incidental operations. Each group will be considered separately.

Presented at the annual meeting of the Kentucky Surgical Society at Cincinnati, May 26, 1962.

TABLE I

INTRACTABILITY—47 CASES

OPERATIONS PERFORMED

Operation	Number	Total
Polya type of Subtotal Gastrectomy	24	27
Billroth I type of Subtotal Gastrectomy	3	
Subtotal Gastrectomy plus Vagotomy	1	
Vagotomy and Gastroenterostomy	18	19
Vagotomy and Pyloroplasty	1	

COMPLICATIONS—6 (12.7%)

Complication	Number
Stomal Malfunction following Subtotal Gastrectomy Re-operation—Recovery	2
Fecal Fistula from Transverse Colon following Subtotal Gastrectomy (Re-operation—Recovery)	1
Stomal Malfunction following Vagotomy and Gastro-enterostomy (Re-operation—Recovery)	1
Persistent Stomal Obstruction following Vagotomy and Gastroenterostomy (Death)	2

DEATHS—2 (4.2%)

Intractability

Of the 47 cases operated upon because of intractable symptoms it will be seen in Table I that 27 of them were subjected to some form of subtotal gastrectomy; 24 a Polya type and three a Billroth I type; 19 of them had a vagotomy and some type of drainage procedure, while one had a so-called conservative subtotal gastrectomy or antrectomy plus vagotomy.

Complications were found to be extremely difficult to analyze in this series. Follow-up examinations were often inadequate for a variety of reasons. Often the writer's colleagues, whose cases are included in this series, would not agree with him on what constituted a complication. Questionnaires submitted to both patients and surgeons showed such poor correlation that this method of evaluation was abandoned. For these reasons no attempt has been made to determine the incidence of "dumping syndrome," nutritional difficulties or patient dissatisfaction with result.

In this survey a complication is, therefore, defined as any development impairing the normally expected recovery in such a way as to require re-operation or resulting in a fatality, since both of these criteria seem tangible and irrefutable. Using this definition there were six complications, (12.7%), two of which were fatalities, giving a mortality rate of 4.2%.

Two patients had persistent malfunctioning of the gastroenterostomy stoma following subtotal gastrectomy which required re-operation and the performance of entero-enterostomy. Both patients survived.

One patient developed a fecal fistula from the transverse colon following subtotal gastrectomy with a posterior Polya type of gastrojejunostomy. He was re-operated on, with resection of a segment of transverse colon. Recovery ultimately ensued after a stormy course. One patient suffered from persistent stomal obstruction following vagotomy and gastroenterostomy and was subjected to a second operation at which time the gastroenterostomy was dismantled and a pyloroplasty substituted with recovery.

Two patients died on the 11th postoperative day following vagotomy and gastroenterostomy after stomal malfunction with persistent loss of gastric secretions. Autopsy permission was not secured in either case.

Perforation

Table II depicts the fate of the 36 cases presenting themselves with acute perforations of peptic ulcers. It would be interesting to correlate some of these statistics with the duration of the perforation at the time of admission but unfortunately the quality of the charts reviewed would not permit such comparison. Twenty-nine of the perforations were duodenal while seven of them were on the gastric side of the pylorus.

TABLE II

PERFORATION—36 CASES

Finding	Number
Duodenal	29
Gastric	7
Free Air seen by X-ray	20
No Free Air by X-ray	10
X-ray not taken	6

OPERATIONS PERFORMED

Operation	Number	Total
Simple Closure	29	
Excision of Ulcer and Closure of Defect	3	
Simple Closure and Gastroenterostomy	1	
Sleeve Resection of Stomach	1	
Subtotal Gastrectomy (Polya)	1	2
Subtotal Gastrectomy (Billroth I)	1	

COMPLICATIONS—7 (19.4%)

Complication	Number
Pyloric Obstruction (Re-operation—Recovery)	1
Hemorrhage (Re-operation—Recovery)	1
Wound Dehiscence (Re-operation—Recovery)	1
Small Bowel Obstruction (Re-operation—Recovery)	1
Pyloric Obstruction (Re-operation—Death)	1
Pelvic Peritonitis—Aspiration Pneumonia (Death)	1
Death—20 hours postoperative, Cause Undetermined	1

DEATHS—3 (8.3%)

TABLE III

HEMORRHAGE—35 CASES

SOURCE OF HEMORRHAGE

Duodenal Ulcer	24
Gastric Ulcer	9
Marginal Ulcer	2

AVERAGE NUMBER OF TRANSFUSIONS—6.25

OPERATIONS PERFORMED

Subtotal Gastrectomy (Polya type)	24
Vagotomy and Gastroenterostomy	4
Subtotal Gastrectomy (Billroth I type)	3
Vagotomy plus Billroth I Gastrectomy	1
Resection of Marginal Ulcer	1
Wedge Resection of Gastric Ulcer	1
Gastroenterostomy	1

COMPLICATION—9 (25.7%)

Wound Dehiscence (Reoperation—Recovery)	2
Wound Dehiscence (Re-operation—Death)	1
Continued Hemorrhage (Death)	1
Myocardial Infarction (Death)	1
Pulmonary Embolism (Death)	1
Blowout of Duodenal Stump (Death)	1
CNS lesion, Type Undetermined (Death)	1
Sudden Death—Cause Undetermined	1

DEATHS—7 (20%)

Preoperative x-rays of the abdomen in either the upright or lateral decubitus position were taken on 30 of the patients and free air was detected in 20 of these. No x-rays were taken in six cases, probably signifying that the surgeon did not suspect the diagnosis preoperatively.

Simple closure was the procedure of choice elected by the surgeon in 29 cases. In three cases the ulcer was excised before the defect was closed. In one case, gastroenterostomy was added to simple closure. A sleeve resection of the stomach, including a gastric ulcer, was performed in one case. Two patients with recent perforations were subjected to a gastrectomy, one a Polya type and the other a Billroth I.

By the previously mentioned definition, there were seven complications. There was one case each of pyloric obstruction, hemorrhage, wound dehiscence, and a small bowel obstruction, all of whom were operated on again and recovered.

There were three deaths, a mortality rate of 8.3%. One was a pyloric obstruction which was re-operated on with a fatal outcome. One patient died of pelvic peritonitis and aspiration pneumonia. The third patient died suddenly and unexpectedly 20 hours postoperatively and the cause of death was not determined.

Table III deals with the patients coming to surgery because of either massive or repeated bouts of hemorrhage. There were 35 cases and they received an average of 6.25 units each of whole blood during their hospitalization. The source of bleeding was a duodenal ulcer in 24 cases; a gastric ulcer in nine cases, and a marginal ulcer in two cases. Twenty-four patients were subjected to a Polya type of subtotal gastrectomy; four cases to a vagotomy and gastroenterostomy, and three cases to a Billroth I type of subtotal gastrectomy. Four others were subjected to different procedures as shown in the table, namely, vagotomy plus Billroth I gastrectomy; resection of marginal ulcer; wedge resection of gastric ulcer, and gastroenterostomy.

Of the 35 cases, three sustained a wound dehiscence and were subjected to secondary closure. Two of these recovered and one died. There was one death each from the following: Continued hemorrhage, myocardial infarction, pulmonary embolism and blowout of duodenal stump. One patient died from some type of central nervous system lesion, which was present prior to his operation. One patient died rather suddenly and unexpectedly early in his postoperative course. Autopsy permission was not secured. The overall complication rate was 25.7% and the mortality rate 20%. In this series, hemorrhage was the most lethal of the complications of peptic ulcer.

Obstruction

Table IV is an analysis of the 17 cases subjected to surgery for pyloric obstruction. A Polya type of subtotal gastrectomy was chosen by the surgeon in eight cases and a Billroth I in one case. Four patients were subjected to a vagotomy and gastroenterostomy; two received

TABLE IV

PYLORIC OBSTRUCTION—17

Subtotal Gastrectomy (Polya type)	8
Vagotomy and Gastroenterostomy	4
Gastroenterostomy	2
Subtotal Gastrectomy (Billroth I)	1
Antrectomy	1
Pyloric Myotomy	1

COMPLICATIONS—4 (23.5%)

Leakage of Duodenal Stump (Re-operation—Recovery)	1
Hemorrhage following Subtotal Gastrectomy (Re-operation—Recovery)	1
Stomal Obstruction Following Vagotomy & Gastroenterostomy (Re-operation—Recovery)	1
Evisceration Following Vagotomy and Gastroenterostomy (Reoperation—Death)	1

DEATHS—1 (5.9%)

a simple gastroenterostomy; one case an antrectomy, and one case a pyloric myotomy.

There were four cases developing postoperative complications leading to a second operation. Three of these were as follows: Leakage of a duodenal stump; hemorrhage following subtotal gastrectomy, and stomal obstruction following vagotomy and gastroenterostomy. All three survived. The one death was of a 59-year-old patient who developed a rather severe postoperative hemorrhage and who had considerable difficulty with stomal obstruction following a vagotomy and gastroenterostomy, who eviscerated on the seventh postoperative day, was secondarily closed and died three days later. The complication rate was 23.5% and the mortality rate 5.9%.

Suspicion of Malignancy

In this series eight gastrectomies were performed because the ulcers were gastric and the surgeon felt that this approach to the problem was justified on the basis of cancer suspicion; six were of the Polya type and two were Billroth I's. One patient was re-operated on because of postoperative hemorrhage with recovery. One patient was re-operated on twice because of persistent stomal obstruction and ultimately succumbed. It is ironic that this patient was subjected to surgery because of suspicion of malignancy and, incredible as it may sound, the gross specimen was lost by the laboratory. These figures in this small number of cases give a complication rate of 25% and a mortality rate of 12.5%.

TABLE V

PATIENTS SUBJECTED TO A SECOND OPERATION SIX MONTHS OR MORE AFTER THE PRIMARY OPERATION—9

ORIGINAL OPERATION AND INDICATION FOR SECOND OPERATION	SECOND OPERATION
Simple Closure	
Pyloric Obstruction	
Hemorrhage	Subtotal Gastrectomy (Polya type)
Intractability	
Vagotomy and Gastroenterostomy	
Perforation	Simple Closure
Persistent Bleeding	Subtotal Gastrectomy
Intractable Pain	Pyloroplasty
Subtotal Gastrectomy—Polya type	
Persistent Bleeding	Resection of Ulcer
Billroth I Gastrectomy	
Persistent Bleeding	Subtotal Gastrectomy (Polya)
Gastroenterostomy	
Marginal Ulcer	Subtotal Gastrectomy (Polya)

MORTALITY—0

TABLE VI

SUBTOTAL GASTRECTOMY	77	
Complications	12	(15.5%)
Fatalities	4	(5.2%)
VAGOTOMY AND DRAINAGE PROCEDURE	28	
Complications	8	(28.5%)
Fatalities	5	(18.5%)
VAGOTOMY AND SUBTOTAL GASTRECTOMY	3	
Complications	0	

Incidental Operations

Also in this series two patients were subjected to a definitive operation for peptic ulcer when it was an incidental finding in the course of a laparotomy performed for other reasons. Both patients had an uneventful postoperative course.

Secondary Operations

Table V is a tabulation of the patients in the series who were subjected to a second procedure six months or more after the first one. In some cases both operations are included in this series; in some the first operation was done elsewhere, and it is, of course, realized that some patients may have had a second operation elsewhere of which the writer has no knowledge. There were no deaths among these patients.

Complication and Mortality Rate

Table VI is an analysis of the complication and mortality rates by procedure. It will be seen that 77 subtotal gastrectomies were performed with a total of 12 or 15.5% complications and four deaths, a mortality rate of 5.2%. The complication rate of eight or 28.5% and a mortality of five or 18.5% among the 28 cases of vagotomy and drainage procedure cases is very difficult to explain. Four of these five deaths followed long periods of stomal obstruction with loss of all gastric secretions, one of which eviscerated. One debilitated patient with a severe cough sustained a wound dehiscence after discharge from the hospital and died four days after secondary closure. The three patients

subjected to vagotomy and subtotal gastrectomy had uneventful postoperative courses.

Analysis of Deaths

Mortality rates from the literature are confusing, but certain generally accepted norms or averages have evolved over the years even though one often hesitates to give a definite figure. It is thought that the over-all mortality rate for the present series and the rates for intractability, perforation, obstruction, and for the procedure of subtotal gastrectomy are acceptable.

A mortality rate of 20% for patients subjected to surgery for hemorrhage must be considered excessive. Two of the deaths, namely, the one following a wound dehiscence and the one following a duodenal stump blowout, must be attributed to faulty technique. The death due to continued hemorrhage may fall into the same category. The other four are thought to be unpreventable.

The mortality rate for vagotomy plus drainage procedure, five deaths (18.5%), is certainly excessive. If one considers only those performed electively for intractability, the rate drops to 10.5% which is still excessive. A closer scrutiny of these five deaths reveals stomal malfunction with persistent vomiting to be the common denominator, with wound dehiscence and evisceration as a secondary complication in two. The charts suggest that uncorrected electrolyte loss with alkalosis and azotemia preceded death in most. It must be pointed out that all five of the unfortunate deaths occurred early in the series between January 1956 and April 1957 before electrolyte determinations were available and that there has not been a death from this procedure since the latter date. It is felt that the technical deficiency has been corrected. If these five deaths could be lifted from the series by some magic means such as beginning the series in May 1957 instead of 1955, the mortality rates for every category in the present series would drop to comfortable levels.

Conclusions

A series of 166 operations of all types performed upon 145 patients for peptic ulcer or its complications in a small rural hospital is analyzed. The cases are grouped according to the indication for surgery: Namely, intractability, perforation, hemorrhage, obstruction, suspicion of malignancy, and incidental operations. The type of operations performed, the complication rate and the mortality rate for each group are presented.

Cases which came to surgery for a second time six months or more after the primary operation, or what might be termed delayed complications, are presented. The complication and mortality rates according to the surgical procedure performed, regardless of indication, are presented. The mortality rate for hemorrhage is found to be excessive and the rate for vagotomy and gastroenterostomy is excessive. These statistics are heavily weighted by five deaths due to vagotomy and gastroenterostomy performed in a 16-month period between January 1956 and April 1957, before electrolyte determinations were available. If these five cases are excluded, all mortality rates fall well within the generally accepted norms.

The February Issue of

The Journal

Will Carry the Complete Program for the

KSMA Interim Meeting at Covington, March 7, 1963

Duo-Ectopic Pregnancies*†

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Two ectopic pregnancies discovered at laparotomy is a rare incident. A new title for this clinical entity is proposed. A case is reported. A brief review of some of the literature on this subject is presented.

THE occurrence of two ectopic pregnancies, discovered accidentally at the time of laparotomy for unilateral ectopic gestation, has been observed for many years but continues to be a rare incident.

Over the years some reviews of the literature on this entity have created confusion as to the total number of cases which have been reported. Fishback[1] reported a case, established the criteria for this entity, and stated that there were 76 acceptable cases. Hall[2], in 1949, reported that there were 87 cases. Abrams and Kanter[3], in 1948, reported that there were 94 cases. In 1950, Stewart[4] reported a review of the literature and found 140 acceptable cases, one of which was his own. Subsequent reporting suggests that the total reported by Abrams and Kanter is the figure from which new totals are obtained. However, it appears that the true figure has not yet been ascertained since various authors state that only accessible literature has been reviewed.

Stewart pointed out that there is some doubt that all recorded cases have been included, due to (1) inaccessibility of journals; (2) previous disagreement as to acceptability (present criteria should prevent this); (3) no reviewer has recorded all cases in an attempt to document both acceptable and unacceptable cases, which would be invaluable for future reference; (4) many cases are buried in the literature and not listed in the Index Medicus (cases have been found in reviews of all ectopic pregnancies[5,6] from an institution); (5) recurrent or subsequent second ectopic pregnancies have often been reported as bilateral ectopic pregnancies; (6) reports dealing with simultaneous bilateral ectopic pregnancy with exclusion of successive coexistent tubal pregnancies have added to the confusion as to the number of acceptable cases. Therefore, a more accurate review of the literature on this subject may be needed.

The confusion on this subject is further compounded by the use of various titles. The following examples are cited: Bilateral ectopic pregnancy, bilateral simultaneous extra-uterine pregnancy, bilateral tubal pregnancy, coexistent bilateral tubal pregnancy, bilateral simultaneous tubal pregnancy. Upon consultation with the professor and head[7] of the Department of English of the University of Louisville, a new term, duo-ectopic pregnancies, has been designed and proposed in the title of this report, to suggest that there are two ectopic pregnancies present at one time. The text of future reports will establish the location of the two pregnancies.

Case Report

The following case was observed by the author:

Mrs. E. J., aged 35 years, had a normal menstrual period beginning January 21, 1958. She had observed a bloody vaginal discharge since early in February 1958. Pelvic examination on March 22, 1958, revealed the uterus to be in anterior position, soft and compatible in size to that of a 12-weeks gestation. No adnexal mass was palpated. The cervix was well epithelialized and closed. There was a small amount of dark red bloody discharge, apparently uterine in origin.

Conservative management was instituted, but the patient continued to bleed and was admitted to a hospital on March 27, 1958. D. & C. was done on March 28, and the patient was discharged from the hospital the following day. Material obtained at the time of D. & C. was estimated to be the equivalent of four tablespoons in volume. The pathological report in this instance was received about one week after

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**Previously called bilateral ectopic pregnancy, etc.*

†From the Department of Obstetrics and Gynecology, Jewish Hospital, Louisville, Ky.

the patient left the hospital and read "decidual tissue."

The patient disappeared from view until seen on April 29, 1958. During this interval following D. & C. she had observed spotting and lower abdominal and pelvic pain, which was treated as a possible pelvic inflammatory disease by her family doctor. Abdominal examination of this patient revealed a tender mass in the left lower quadrant, reaching almost to the level of the umbilicus. The abdomen was slightly distended. Bimanual examination seemed to establish continuity of the abdominal mass with the uterus and cervix. There was no mass palpated in the right adnexal region. The cervix was very soft and slightly eroded, and there was no evidence of bleeding through the cervical os. The temperature was 98.8, and the pulse 80.

During the course of bimanual examination the mass in the left lower quadrant collapsed. The patient promptly went into shock. The pulse was very rapid and thready, the skin cold, clammy, and wet, and the patient vomited. The abdomen was very rigid and distension became more prominent. The blood pressure was 90/60.

The patient was taken directly from the office to Jewish Hospital. On admission to the hospital the patient was immediately prepared for surgery. The hemoglobin at this point was nine grams and the hematocrit, 31. Admitting blood pressure was 70/40, temperature 97.6, pulse 100, and respirations 18. Intravenous fluids were instituted, and when the operation was begun 500 c.c. of whole blood were administered rapidly.

The operation was performed under sodium pentothal, cyclopropane, and oxygen anesthesia. Flaxedil was given three times in small divided doses.

On opening the abdominal cavity, a small peritoneal entry was made, and 500 c.c. of blood were removed and administered as an autotransfusion, which was followed later by an additional 500 c.c. of whole blood and 500 c.c. of 5% dextrose in water. The pelvic cavity was then exposed by removal of free and clotted blood. On the left was found a fetus (72 mm. crown-rump length) lying free in the peritoneal cavity, attached by an umbilical cord to a placenta appearing like a pancake implanted upon the opened left tube and flattened and thinned left ovary. The tube appeared to have been ruptured at some earlier time. The sudden intraperitoneal hemorrhage was apparently the result of rupture of the amniotic sac and partial placental detachment from these structures.

The left infundibulopelvic ligament, left mesosalpinx, and cornual end of the left tube were clamped, cut, and ligated, excising the left ovary and tube with attached products of conception. All bleeding was controlled at this point. The right tube was then inspected and at the mid-portion found to contain a firm, hemorrhagic, reddish-purple mass, about 4.5 cm. in greatest diameter. The fimbriated end of this tube was distended and cystic and about 2 cm. in diameter. The cornual portion of the right tube and mesosalpinx were clamped, cut, and ligated, excising the right tube. The abdominal wall was then closed, and the patient left the operating room in slightly less than one hour after beginning the operation.

Pathological Report

The pathological report confirmed the gross findings of pregnancy on the left. The following is a description of the right tube: "The fimbrial end is cystic, sealed, and is 3.5 cm. in diameter. The middle third is a fusiform mass 4.5 cm. long. This has been opened. It apparently communicates with the cystic bulbous end and has a wall 12-16 mm. thick. The cavity is serous-lined. The cornual end of the tube is not remarkable" (Figure 1).

The microscopy report of sections of this tube is as follows: "The fusiform swelling of the right tube proves to be a mass of necrotic placenta which has infiltrated almost to the serosa. The necrosis is in the coagulation stage. Some of the villi are partly calcified. Through-

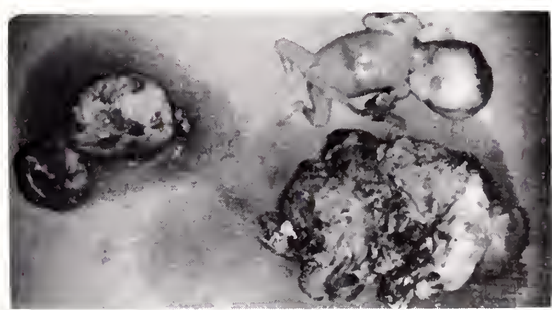

Figure 1. Fusiform mass in middle third of right tube, on left, has been opened. On right are left ovary and tube with attached fetus and placenta.

Figure 2. High power field of section of fusiform mass of right tube showing necrotic placental villi in wall of tube.

out the whole mass there are practically no nuclei, but the general structure of the placenta can be identified" (Figure 2).

This patient made a satisfactory and rapid recovery and was discharged on May 5, 1958.

Comment

Weder, et al[8], raise the question whether this condition might be more common than would appear. Hall[2] stated that since Tait published his observations, the literature on extra-uterine pregnancy has become so voluminous that a complete review would prove practically impossible.

Including the case reported herein, 25 additional cases[9-21] are recorded in the literature accessible to the author. No attempt will be made to suggest that a final tabulation through November 1961 has been made. The practicability of a thorough review of the literature arouses some doubt as to its attainment.

I will agree that the entity, duo-ectopic pregnancies, is rare and unusual. Its incidence has not been definitely ascertained. Very likely some cases have not been reported. Some future hardy investigator may undertake the task to review all literature devoted to ectopic pregnancy and tabulate the number of acceptable cases which have been reported.

Summary

1. A case of duo-ectopic pregnancies is reported.

2. A new title, duo-ectopic pregnancies, is proposed.

3. The incidence and exact number of cases of this rare entity have not yet been ascertained.

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Vagotomy and Pyloroplasty for Duodenal Ulcer: Evaluation of 15 Years' Experience*

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Fifteen years' experience with 330 patients treated by vagotomy-pyloroplasty are reviewed. A mortality rate of less than 1% and a cure rate of 96% would appear to make it the procedure of choice for the complicated duodenal ulcer.

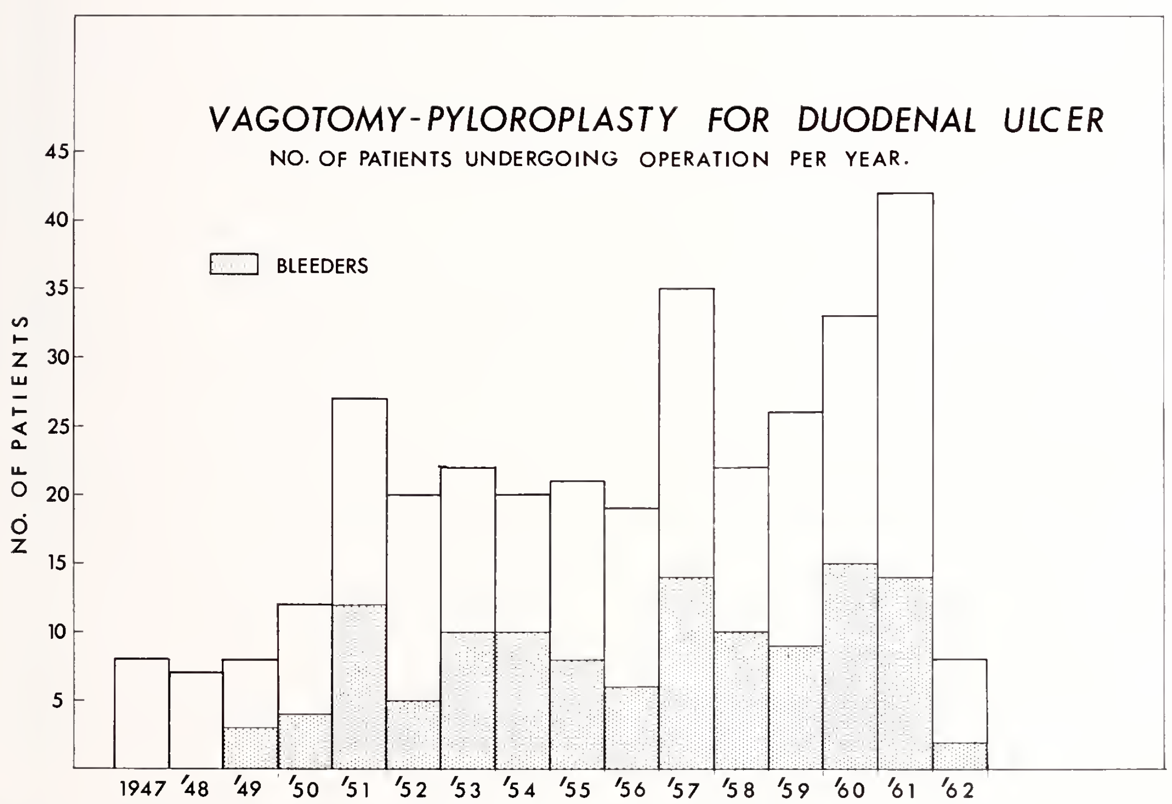
Introduction

AT THE first meeting of the Kentucky Surgical Society, my late partner, Jack Webb, M.D., and I[1] gave a preliminary report on our first 22 duodenal ulcer patients that had been treated by vagotomy and pyloroplasty. The satisfactory results obtained in those early cases and our continued satisfaction with the procedure have persuaded us that it is the procedure of choice for the complicated duodenal ulcer. Others, notably Weinberg[2], Farris[3] and Wilkins[4] in this country, and Norman Tanner[5] and Harold Burge[6] in England, began using the procedure at about the same time and have continued its use with results that are comparable to ours.

Since 1947 my partners and I have treated a total of 330 patients with proved duodenal ulcer by this method. The average number of patients treated each year since 1951 has been about 25 with a high of 42 patients treated in 1961 and a low of 19 patients treated in 1956 (Table 1). It is interesting to note that more patients were treated during the recession years than during good times. The shaded portion of each bar in Table 1 indicates the number of

*Presented at the annual meeting of the Kentucky Surgical Society at Cincinnati, May 26, 1962.

TABLE 1



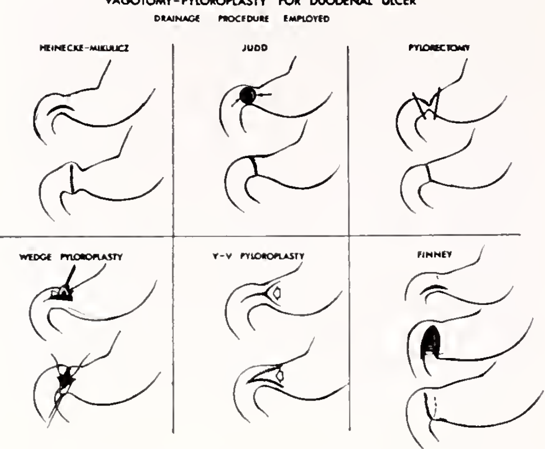


Figure 1. Various types of pyloroplasty employed. Finney procedure now used almost exclusively.

patients treated in that year in which bleeding was a problem. Incidentally, all of our bleeders are included in this report.

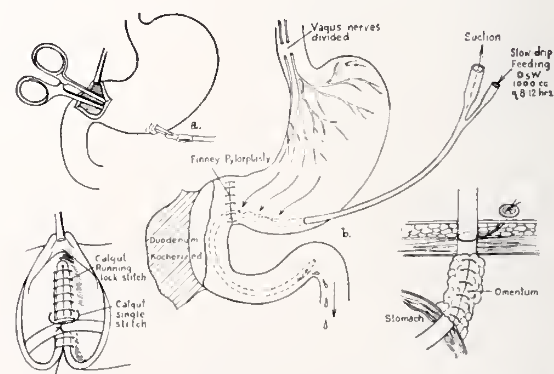
Evolution of Technique

In 1947 the procedure of vagotomy and pyloroplasty was entirely new to us and its technique had to be mastered by trial and error. In the previous year, Arnold Griswold, M.D., had been most kind in demonstrating to us the transthoracic technique and this was of considerable help when we began to use the abdominal approach. Certain errors occurred that have since been avoided by variations and improvements in technique. For example, we have learned that it is not necessary to reflect the left lobe of the liver in order to expose the esophageal hiatus region. This has minimized the risk of troublesome bleeding from veins lying along the under surface of the diaphragm anterior to the hiatus. Also, we have learned that the main vagus trunks can be more readily picked up in toto without injury to blood vessels or to the esophagus or stomach if the esophagus is pulled well down into the abdomen and the dissecting finger is kept well above the esophago-cardiac junction. Also, we have learned to avoid tension and risk of injury to the vessels along the splenic pedicle by applying traction along the lesser curvature of the stomach and avoiding traction on the greater curvature.

As regards the pyloroplasty, we have tried all of the methods depicted in Figure 1. These include the Heineke-Mikulicz and the Judd pylorectomy with end-to-end hook-up, wedge pyloroplasty, Y-V pyloroplasty and the Finney procedure which we now use exclusively. At the beginning of our experience, we were of the opinion that the ulcer should be excised or excluded from the gastrointestinal tract and did this laboriously and, I fear, with considerable unnecessary risk to the patient, since the only death directly related to the procedure occurred from pancreatitis in just such a case. Since then, we have been content to leave the posteriorly situated ulcer strictly alone, unless bleeding, in which case the bleeding is brought under control by means of suture ligatures of chronic catgut. It is our understanding that most of the complications and deaths that occur following antrectomy or gastrectomy are related to dissection in this area.

For the first eight or nine years we did not use a gastrostomy tube or nasogastric suction postoperatively as a routine measure. An instance of complete postoperative gastric retention led us to devise a feeding-suction type of gastrostomy tube[7] (Figure 2). This tube, which is a modified #20 French Foley catheter, provides a positive avenue for feeding since it traverses the anastomotic area and at the same time provides for gastric decompression. Also, it avoids the need for parenteral fluid replacement. All this greatly simplifies postoperative care and makes for increased patient comfort.

The obstructive difficulty in the patient just mentioned was relieved by gastroenterostomy on the 14th postoperative day. This gave us an



By permission of SURGERY, GYNECOLOGY & OBSTETRICS.

Figure 2. Author's feeding-suction gastrostomy tube is an ordinary #20 French Foley catheter, modified by opening the balloon and cutting several windows in the side of the main lumen of the catheter. It permits simultaneous feeding and suction.

opportunity to inspect the previously constructed Heineke-Mikulicz pyloroplasty. We found the reason this pyloroplasty did not function was that the newly constructed pyloric canal was compressed from front to back by being stretched across an enlarged, edematous, inflamed pancreas (Figure 3). For this reason, we began using the Finney pyloroplasty and have found that this anteroposterior compression does not occur when the side to side in continuity anastomosis is performed. Aside from being easier to perform, the Finney pyloroplasty can be extended well down along the second portion of the duodenum if there is tubular cicatricial narrowing in this region.

We have found through experience that pyloroplasty can be performed in almost every case of duodenal ulcer. During this same period of time, gastroenterostomy was found to be necessary in only 13 additional patients where the anatomic or pathologic situation precluded the performance of a satisfactory pyloroplasty.

Postoperative Care

As regards postoperative care, we have found that if one takes into account the temporary gastric atony and later the absence of a pyloric valve, most of the side effects can be avoided or ameliorated. We avoid over-distention of the temporarily atonic stomach by constant gastric suction the first five postoperative days. For the next three weeks the patient is given small, close interval feedings of anything he chooses to eat so long as he chews it thoroughly. As an aid to gastric emptying, he is instructed to recline on his right side for a few minutes after each feeding. Any sense of fullness is a signal to reduce the frequency and/or amount of feeding. Foul belching calls for periodic gastric decompression. This is easily accomplished by self-induced vomiting.

Later on, as operative edema subsides, the lack of a pyloric valve may allow premature jejunal overload. This may produce symptoms of the dumping syndrome or abdominal cramping and diarrhea. Generally, restriction of sweets and fluids is sufficient to overcome this. Occasionally, a patient will have to stay on a fairly strict bland diet, avoiding grease and carbonated drinks and the like, for a prolonged period until the small bowel becomes adjusted to the new situation.

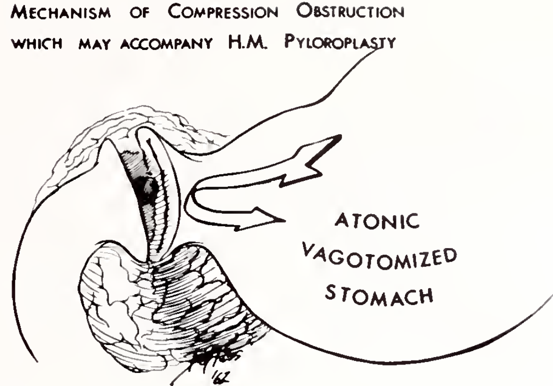


Figure 3. Relative obstruction due to stretching and compression of newly constructed pyloric canal over a prominent edematous head of the pancreas.

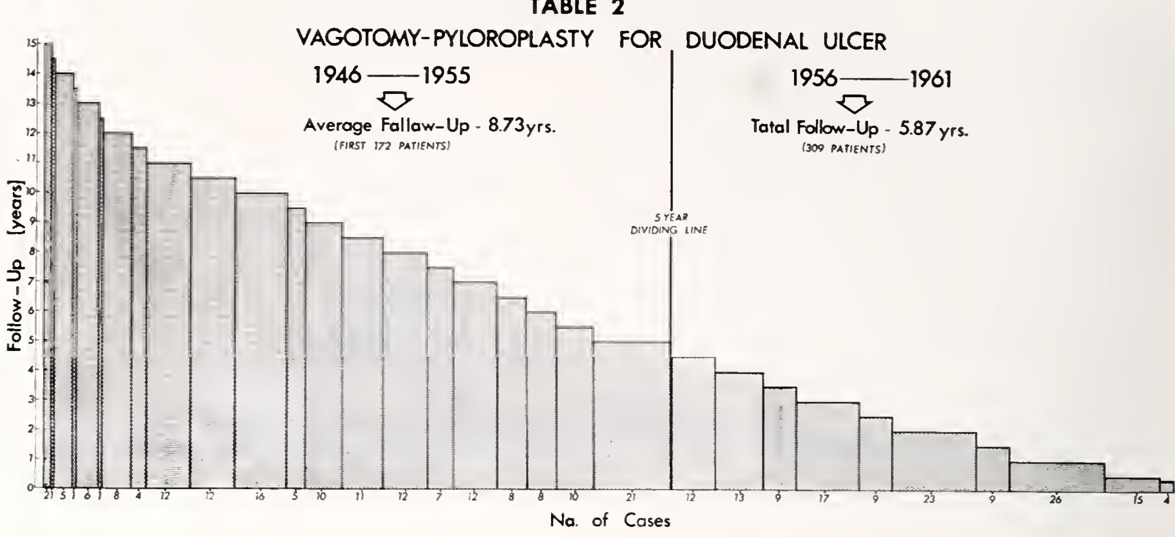
Complications

We have had our share of complications, but with experience these have been minimized and have been practically non-existent in the past six or seven years. These complications include: 1) Inadvertent tearing of the splenic pedicle necessitating splenectomy in one patient. 2) Severe postoperative hemorrhage in the subphrenic space secondary to failure to ligate a vessel adjacent to a severed nerve. This required re-exploration to control the bleeding. 3) An anastomotic leak occurred in one patient who had had a pylorectomy. This produced a temporary duodenal fistula. 4) Postoperative hemorrhage has occurred in two patients, neither of whom had bled preoperatively. Both of these required re-operation to control a bleeding point in the anastomosis. 5) There have been two disruptions and both of these patients developed incisional hernia. 6) Complete retention occurred in one patient following Heineke-Mikulicz pyloroplasty. This had to be relieved by gastroenterostomy on the 14th postoperative day.

Side Effects

Among the side effects usually mentioned as occurring after vagotomy, we have had 10 with mild to moderate dumping and six with troublesome diarrhea. These have been kept reasonably well by adjustment of diet. Eight patients had dysphagia due to cardiospasm which lasted from the end of the second week up to the end of the third or fourth week. Two of these required two dilatations each and all are now well.

TABLE 2



General Statistics

Analysis of the 330 patients operated upon show that 248 were males and 82 were females. There were only 18 Negroes in the group. Nearly all of these patients came from our private practice. Only a few were from the charity services. The average age was 45 years with the youngest patient being a 7-year-old boy and the oldest a man of 78. The average duration of symptoms before surgery was nine years and the average hospital stay was 7.4 days. This reflects minimal associated morbidity.

Of the 330 patients, 53 gave a history of previous perforation. Significant obstruction was present in 78 and bleeding of significance occurred in 122. Fifty-one of these bleeders had exsanguinating hemorrhage and required emergency surgery. These have been reported elsewhere.

Follow-up

Follow-up has been by questionnaire, by personal interview and by personal communication with the family physician in some cases. Follow-up is slightly over 92%. Of 309 patients traced, who were operated upon between January 1947, and the present date, the average follow-up time has been nearly six years (Table 2).

Results

Deaths—There have been three operative deaths among the 330 patients. Only one of these deaths was directly related to the technical procedure (Table 3). This death occurred in the patient mentioned previously who died of pancreatitis following pylorectomy and end-to-end hook-up. The other two deaths were proved by autopsy to be cardiovascular in nature. One was the result of a coronary thrombosis in a 64-year-old man who had been home from the hospital one day, and the other was a 47-year-old woman who had been home from the hospital one week when she threw an embolus to the brain through a patent foramen ovale. There have been no operative deaths among our bleeders.

TABLE 3

VAGOTOMY-PYLOROPLASTY FOR DUODENAL ULCER
ANALYSIS OF DEATHS
330 OPERATIONS

Case	No. of Days Postoperative	Cause
1. 66 year W.M.—Pylorectomy with end to end hook-up	(in hospital) 14	Pancreatitis
2. 64 year W.M.—Finney-plasty	(at home) 18	Coronary Thrombosis
3. 47 year W.F.—Finney-plasty	(at home) 19	Cerebral Embolism

TABLE 4

VAGOTOMY-PYLOROPLASTY FOR DUODENAL ULCER
ANALYSIS OF FAILURES
12 OF 330 PATIENTS

Number of Patients		Apparent Cause	
Re-operation for recurrent D.U.	4	Incomplete Vagotomy	3
Re-operation for Stasis Gastric Ulcer	3	Inadequate Pyloroplasty	2
		Obstruction by Superior Mesenteric Artery at the Ligament of Treitz	1
Re-operation for Pyloric Stricture (No Ulcer Found)	2	Technical Error	2
Recurrence; on Medical Management	3	Incomplete Vagotomy	1
		Inadequate Drainage	2

Failures—Twelve (3.8%) of our patients have been classified as failures (Table 4). Four of these developed recurrent duodenal ulceration and three of these were found to have had an incomplete vagotomy. Five other patients were subjected to re-operation in order to correct an inadequate drainage operation. Of these five, three had developed stasis gastric ulcers. The remaining three patients have developed typical ulcer symptoms and findings, but prefer medical management to re-operation.

There has been no instance of recurrent bleeding in the immediate postoperative period among the bleeders. However, six of our 122 bleeders have had subsequent bleeding and three of these proved at re-operation to have a recurrence of duodenal ulcer. These are included in the overall results. The other three recurrences of bleeding occurred in chronic alcoholic patients and the bleeding was presumed to be due to the ravages of alcoholism since x-ray and acid studies have been consistently negative for duodenal ulcer.

A summary of results shows that of those traced, 96% were improved and that about 4% failed to benefit from the operative procedure. The mortality rate was 0.9% (Table 5).

TABLE 5

VAGOTOMY-PYLOROPLASTY FOR DUODENAL ULCER
RESULTS IN 330 PATIENTS—1947-1962
309 TRACED—AVERAGE, 5.9 YEARS

Results	Number of Patients	%	
Excellent	277	89.6	96.1
Good	7	2.3	
Fair	10	3.2	
Failure	12	3.9	
Deaths (330 operations)	3	0.9	

Recent Results

With increasing experience our results have been much more satisfactory. Among our last 138 patients there has been only one questionable recurrence and no deaths related to the technical procedure. These last 138 patients have all had the Finney pyloroplasty and feeding-suction gastrostomy.

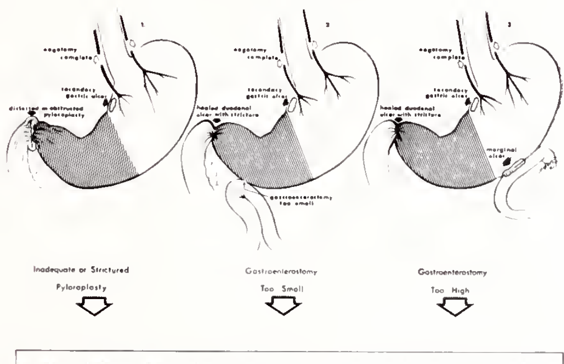


Figure 4. Common drainage errors.

Causes of Failure

From a review of the literature and from an analysis of our own work we have concluded that recurrences are mainly due to one of three causes. Incompleteness of vagotomy causes persistence or recurrence of duodenal ulceration. This usually becomes evident within the first year just as though no treatment had been given. An inadequate drainage operation produces antral stasis (Figure 4). This causes a continuous release of gastrin and hypersecretion of hormonal origin, which in turn, may lead to the development of gastric or marginal ulceration.

A gastroenterostomy stoma that is too small or too high along the greater curvature of the stomach also leads to antral stasis and results in gastric or marginal ulceration. It is easy to place the gastroenterostomy too high, particularly in the patient with a large, obstructed, sagging stomach. As the obstruction is overcome, the stomach shrinks and pulls the originally satisfactory dependent gastroenterostomy up in to a position where it no longer drains efficiently. If gastroenterostomy is used, it should be ample and the stoma should be placed within one inch of the pylorus and along the greater curvature.

We have, as yet, not seen or recognized a Zollinger-Ellison tumor. And for this we are grateful, since we understand that the present approved treatment of this syndrome is total gastrectomy coupled with a near total pancreatectomy.[9]

Discussion

The rationale of vagotomy is now well understood and is gaining general acceptance as a means of controlling the hypersecretion associated with duodenal ulcer. There still remains considerable difference of opinion regarding whether antrectomy or a drainage procedure simpler than antrectomy should be employed. We are persuaded by this experience that the antrum does not have to be sacrificed. An adequate pyloroplasty eliminates resting antral release of gastrin but preserves its normal periodic and beneficial response to the intake of food. Also, there is increasing evidence to show that the antrum is an important regulator of digestion. For these reasons, and aside from the greater risks involved in performing antrectomy, we would like to make a strong plea that the antrum be preserved.

Summary

1. 330 patients with proved duodenal ulcer including those with all degrees of bleeding, undergoing vagotomy and pyloroplasty from 1947 until 1962, are presented. Follow-up is complete in 92%.

2. There have been three operative deaths (0.9%).

3. There have been 12 known failures (3.9%). Presumably, these have been due to either incomplete vagotomy, inadequate drainage, or both.

4. Since 1957, in our last 138 patients, there has been only one questionable failure. This success we attribute to refinement in technique and the more efficient drainage afforded by Finney pyloroplasty.

Conclusion

This extended experience has persuaded us that vagotomy-pyloroplasty is a safe and reasonably effective remedy for the treatment of the complicated duodenal ulcer.

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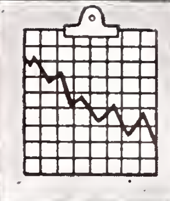

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Long-Term Use of Sitosterol As a Hypocholesterolemic Agent

CHARLES H. DUNCAN, M.D. AND MAURICE M. BEST, M.D.* †

IN 1954 we reported that the administration of the plant sterol, sitosterol, resulted in modest but sustained reduction in serum cholesterol.[1] Of the patients participating in this original study, two continued to receive sitosterol for periods of five or more years. In view of the recently reported toxicity[2, 3] and undesirable side effects[4, 5] of other hypocholesterolemic agents, a review of the above two cases would seem appropriate.

Patients Seen Each Week

The patients were seen at intervals of one week early in the study, and monthly or more often throughout the entire period of observation. At each visit blood was collected for determination of serum total cholesterol by the method of Abell et al.[6] Laboratory profiles for evidences of toxicity were completed twice a year.

Patient A.C., a 58-year-old Caucasian male, was referred to our clinic by his physician with a diagnosis of peripheral arterial insufficiency. Serum cholesterol was reported to be in the range of 300 mg./100 ml. The patient requested that he be placed under treatment since both he and his physician believed that he was developing early peripheral arterial disease.

On September 2, 1953, A.C. was admitted to the original double-blind study to determine the effects of sitosterol on serum cholesterol. The course of the serum cholesterol changes is depicted in Figure 1. For six of the eight years of the study, the patient ingested 18 to 20 grams of sitosterol daily, a total intake of approximately 90 pounds. No clinical evidence of side-effects or of toxicity was noted.

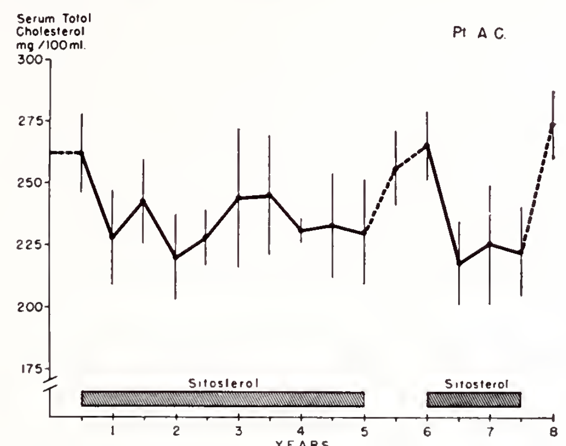

Figure 1. Patient A.C. The response of the serum total cholesterol to the administration of sitosterol (solid line) and placebo (broken line). Each point represents the mean of all determinations for the six-month period; the variability (standard deviation of the mean) is indicated by the vertical line at each of these points. The length of this line indicates two standard deviations of the mean.

Normal Determinations

At the completion of the study, the following determinations were normal: Complete blood count, urinalysis, serum non-protein-nitrogen, sodium, potassium, calcium, carbon dioxide content and chloride. Normal liver function was indicated by the following normal tests: Cephalin floculation, thymol turbidity, total protein, albumin/globulin ratio, prothrombin activity, alkaline phosphatase, glutamic pyruvic transaminase and sulfobromophthalein retention. Electrocardiograms and roentgenograms remained normal. Body weight increased by 10 pounds during the study. The

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†Acknowledgements: The authors are grateful to G. Randolph Schrodt, M.D., for the autopsy evaluation of patient J. H. Financial support and the supplies of the sitosterol suspension were generously furnished by Eli Lilly & Company. During the latter part of the study commercially available Cytellin®, Lilly, was used.

patient remains under our observation and is actively employed.

Patient J.H., a 69-year-old Caucasian female, was referred to the Cardiology Service in 1951 because of chest discomfort brought on by exertion and relieved by rest.

The onset of the present complaint followed an attack of "acute indigestion" which occurred eight months prior to the clinic visit. This episode awakened the patient in the early morning and consisted of severe upper abdominal pain accompanied by profuse perspiration and marked apprehension. She noted improvement in about two days but remained semi-bedfast for a month. The chest discomfort was noted when she first became ambulatory. She had sought no treatment for this condition in spite of the occurrence of pain five to eight times daily.

Physical Examination

Physical examination revealed a comfortable female who appeared younger than her stated age. Pertinent findings were confined to the cardiovascular system. The heart was enlarged; the rhythm regular and the rate 80 per minute. A systolic murmur was present at the base which was maximum at the third interspace to the left of the sternum. The blood pressure was 160 systolic and 88 diastolic. There was no evidence of congestive heart failure.

Chest roentgenogram showed cardiac enlargement with aneurysmal dilatation of the ascending aorta with calcium deposits within the wall. The resting electrocardiogram demonstrated left ventricular enlargement with the suggestion of an old posterior wall myocardial infarction. The clinical diagnosis was arteriosclerotic heart disease, old posterior wall myocardial infarction, anginal syndrome, and possible aortic stenosis.

During the next two years this patient was seen at biweekly intervals as a member of a group of patients subjected to a series of drugs to evaluate their possible efficacy in the management of angina pectoris. As part of the study she had repeated exercise tolerance tests which were consistently abnormal and serum cholesterol determinations which were abnormally elevated.

On October 15, 1953, J. H. was admitted to the sitosterol study. The course of the changes in serum cholesterol is shown in Figure

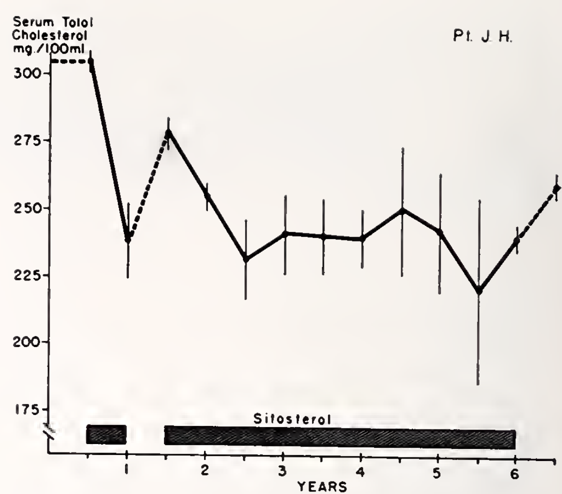

Figure 2. Patient J.H. Responses to drug and placebo administration are indicated as in Figure 1. The variability of serum cholesterol during both placebo and treatment periods noted in these patients is not uncommon; this indicates the need for prolonged observation of the patient in any study concerned with the evaluation of hypocholesterolemic agents.

2. Her clinical course was complicated by the onset of persistent atrial fibrillation in 1956 resulting in chronic congestive heart failure of sufficient severity to cause her admission to a chronic disease hospital in which she resided throughout the remainder of her illness. She experienced an embolus to her left middle cerebral artery in April 1957. Treatment with sitosterol was continued until June 1958, at which time a placebo preparation was again substituted. Three months later the patient died shortly after an episode of chest pain and hemoptysis.

No Signs of Drug Toxicity

At no time during the long period of drug administration (total consumption of approximately 75 pounds) did the patient exhibit signs of or symptoms of drug toxicity. At the completion of sitosterol administration, the following laboratory determinations were within normal limits: Complete blood count, urinalysis, serum non-protein-nitrogene, chloride and CO_2 content. The following indices of liver function were also normal: Cephalin floculation, thymol turbidity, total protein, albumin/globulin ratio, alkaline phosphatase, pro-thrombin activity and glutamic pyruvic transaminase.

At autopsy, death was attributed to a fresh area of pulmonary infarction due to an embolus.

The heart was enlarged, weighing 470 grams and had a large area of old infarction on the posterior wall of the left ventricle. The ostium of the right coronary artery was narrowed and the ostium of the left coronary artery was partially occluded by an atheromatous plaque. The coronary arteries showed extensive atherosclerosis with marked narrowing of the lumina. Extensive atherosclerosis was also present in the aorta and the renal arteries.

The liver weighed 960 grams and was normal to microscopic examination. The gallbladder contained about 20 multifaceted stones. Moderate pulmonary emphysema was the only other organ abnormality. The bone marrow was not remarkable.

Discussion

Sitosterol is generally considered to exert its hypocholesterolemic effect by interference with the intestinal absorption of cholesterol. Though less well absorbed than cholesterol, sitosterol is absorbed to some extent[7, 8]. Indeed, Curran and Costello noted the presence of atheromatous plaques in the aortas of four rabbits fed soy sterols (predominately sitosterol), and using an indirect analytic method reported appreciable amounts of the soy sterol in both liver and aorta; from this they concluded that ingestion of soy sterol might be hazardous[9]. A critical analysis by Shipley et al of the techniques employed casts grave doubt on the validity of these observations and repetition of the study by these investigators, employing a more direct and sensitive method of sterol analysis, failed to detect any soy sterols in liver, aorta or other tissues[10].

The failure of absorbed sitosterol to accumulate in blood or tissues is apparently a consequence of its ready metabolism to bile acids and excretion in the bile. Studies have failed to detect any specific biologic effect to the absorbed sitosterol; it is not converted to cholesterol, and does not have a demonstrable inhibitory effect on cholesterol synthesis by the liver[7]. That sitosterol can serve as a precursor of steroid hormones has been demonstrated by tracer studies[11].

Reduction in Serum Cholesterol

The mean reduction in serum cholesterol noted in Patient A.C. (13%) and in Patient J.H. (14%) is in accord with our usual experience with sitosterol administration.

The use of any agent to lower serum cholesterol in man must be considered to be empiric since there is as yet no convincing evidence that reduction of serum cholesterol will prolong life in patients with atherosclerotic disease. The extensive atherosclerosis present at autopsy in patient J.H. certainly does not suggest that any significent regression of lesions resulted from the five-years' treatment with sitosterol. In view of this uncertainty as to patient benefit, the selection of a hypocholesterolemic agent must include careful consideration of possible toxic effects. Although sitosterol administration has the disadvantages of inconvenience, expense and limited effectiveness, it appears to be safe for use for long periods of time.

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A complete List of KSMA Councils and Committees Is on Page 73

EDITORIALS

Driver Limitation and Smallpox

THE 20TH Century American epidemic phenomenon of highway deaths now has exceeded 1,300,000 fatalities and is on the increase in Kentucky. Widespread use of vaccination as urged by physicians has reduced a rare case of smallpox to a negligible public health hazard. Nonetheless, one appropriately reports and quarantines such communicable hazards. Currently, this is not true in Kentucky for impairment of ability to operate motor vehicles.

A driver impaired by acute medical disturbances or chronic disease, however, easily may wipe out a school bus full of children or another family group innocently en route to church.

Kentucky Revised Statutes (186.440, paragraph 6) require the State Police to deny a driver's license to "any person with physical or mental disability which would interfere with the exercise of reasonable and ordinary control over a motor vehicle." Yet, no valid procedure exists to implement this charge.

Pennsylvania, at one extreme, now is subjecting all drivers to "complete" physical examinations. New York State, at the other extreme, holds that this is an unjustifiable burden for a small percentage yield.

This Committee feels that as Kentucky physicians we should assume leadership in a middle-of-the-road formalization of sound medical judgment. Every physician cautions some patients about driving limitation and at times advises against vehicle operation. Many intelligent patients decline night driving voluntarily (because of early cataracts), avoid expressways (because of slow reaction time or mechanically restricting arthropathy), or don't drive at all (because of resting dyspnea or uncontrollable seizures).

Our Kentucky Department of Health and Safety now have under study administrative regulations whereby "driver limitation" would become a reportable medical problem similar to that of smallpox or tuberculosis but subject to appropriate review and appeal.

This mechanism, like the sanitary management of sewage, seems feasible within longstanding but lightly guarded provisions of KRS. Such directives will add some responsibilities, at times onerous, to the practicing physician, but physicians are manifestly those who must make such medical decisions.

Our forefathers created this nation of remarkable freedoms around the policy that one man's liberty may extend to where the next man's nose begins. Vigilance is required to protect the rights of the capable as well as the handicapped who are properly treated or compensated. The old dictum may be paraphrased that one man's liberty must end where the next man's fender begins.

The general areas of "driver limitation" will be outlined in consultation with the various statewide medical groups, such as orthopedic, eye and ear, medical, psychiatric, and arthritic societies. Preliminary advice already has been sought from each of these; but decisions in individual cases, as in all clinical diagnoses, will rest on the responsible judgment of individual physicians.

Each member of the medical profession in Kentucky is urged to consider maturely the depth of this responsibility and freely advise members of this committee of any constructive suggestions.

KSMA HIGHWAY SAFETY COMMITTEE
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Tragedy Of The Year

THE MOST tragic and disturbing event in medicine during the past year has been the prenatal deforming effect of the drug thalidomide. Much has been said and written. New and more stringent regulations for the testing and marketing of new drugs have been proposed and will be made effective. The medical profession and the pharmaceutical industry have undergone a year of rigid and sometimes bitter investigation and have come out remarkably free of blame.

The drug was discovered by a German pharmaceutical company in 1954 and studied by them intensively. Their findings were published in December 1955. A company in England began testing it in July 1956. They made independent pharmacological investigations and conducted extensive clinical trials. The results were presented before medical and other scientific groups. Clinical use had led to the conclusion that it was an exceptionally safe and effective drug. It was marketed first in April 1958.

Doctor MacBride in Australia deserves great credit for studying the first six cases of deformities which led to the suspicion that thalidomide was a causative factor This teratogenic effect (the production of congenital malformation) of the drug was presented at a German medical meeting on November 20, 1961. By December 5, 1961 the pharmaceutical company in the United States manufacturing thalidomide had notified the Food and Drug Administration and as nearly as possible all American physicians who were investigating the drug for them. All supplies were recalled and as wide publicity as possible was given to its harmful effects.

Despite this prompt action by manufacturers and physicians abroad and here many deformed infants have been born in other countries and a few in the United States from use of the drug during the first trimester of pregnancy. It is thought that the harmful effects are produced during a very brief period, perhaps 10 days, when the extremities begin development. The deforming effects have not been confined to the extremities however.

What can be done to prevent the occurrence of such unhappy results with new and otherwise useful drugs? Are our present regulations of investigation, testing and manufacture adequate to ensure safety What better safeguards can be provided? The U.S. Food and Drug Administration, The Council on Drugs of the AMA, the recently organized Commission on Drug Safety of the Pharmaceutical Manufacturers Association, and similar councils of medical and drug research in other countries are undertaking diligently and promptly to prevent such a recurrence. We as physicians must be ever on the alert.

The best scientific opinions are that the damaging effects of thalidomide could not have been anticipated. No similar tragedy had ever occurred before. We pray that the means may be found to prevent such an experience from ever occurring again.

Sam A. Overstreet, M.D.

SPECIAL ARTICLES

Kerr - Mills as the Administrator Sees It—At The State Level*

Earle V. Powell

Commissioner, Kentucky Department of Economic Security

Frankfort, Ky.

I AM particularly interested in the theme of your conference—"Kerr-Mills in Action—1962." As the administrator of Kerr-Mills for the Commonwealth of Kentucky, I have seen this program in action in my own State not only in 1962, but in 1961 as well, the year we began medical care for our needy. It is my intention today to report to you how my State, Kentucky, put Kerr-Mills in action and how it has been doing since then.

Earle V. Powell

In Kentucky, you might say, Kerr-Mills and I were put into action at the same time. I was appointed Commissioner of the Department of Economic Security, with responsibility for the medical care program, on January 6, 1961. The Kerr-Mills program began operating in Kentucky on January 1, 1961, so we have more or less grown up together. But, to properly explain Kerr-Mills in Kentucky, it is necessary to go back before that time.

Kentucky Is Low-Income State

As most of you know, Kentucky is a relatively low-income state, one of the poorer, although it has been making some gains in the past two or three years. As such, it may be difficult to explain how we happen to be one of 27 states in the nation capable of providing the financial support for such a program. This is especially obvious when Kentucky finds itself in company with such high-income states as New York, California, Michigan and Pennsylvania, while only six other states of the 27 are our neighbors in the South with comparable financial capabilities.

In 1959, the voters of Kentucky approved a sales tax to finance the payment of a bonus to the State's veterans. The Kentucky Legislature, in its 1960 regular session, set this sales tax at 3%, providing the State with sufficient revenue to pay the veterans' bonus and, additionally, to boost Kentucky's general fund by several million dollars. This same legislature, equipped for the first time in the State's history with sufficient funds to do so, passed legislation giving Kentucky's public assistance recipients a medical care program, to go into effect January 1, 1961. This program was to eliminate the previous method of adding $4 per month to a recipient's subsistence check for medical care. It implemented a Federal program that had been in effect for the past 10 years, with medical payments going to vendors.

Later that year, in September, Congress passed the Kerr-Mills Act, expanding the existing medical care for public assistance recipients and creating a new category, Medical Assistance to the Aged. Kentucky's Legislature had already adjourned. However, a special session had been called and was due to meet during that same month. With the expectation of adding the Kerr-Mills program for the aged to the already agreed-upon public assistance program, medical care was put on the Legislature's agenda.

State In Ideal Position

Thus, Kentucky was in an ideal position. New money had just been put into the State's revenue fund and had not yet been diverted into other areas. We were already prepared to undertake medical aid for public assistance recipients and a special session of the Kentucky Legislature had just been called. As a result of this readiness, in September 1960 Kentucky became the first State in the Nation to pass legislation implementing the Kerr-Mills Act.

From that time until January 1, 1961, we worked at preparing the program for operation. Medical care in Kentucky is set up under the Department of Economic Security which, under provisions of the law, contracts with the State Department of Health for the medical aspects of the program. In addition to the departmental responsibility, there was established a Medical Advisory Council. This consists of 11 members, appointed by the Governor for staggered terms. Its function is to recommend to the Commissioner of Economic Security and the Commissioner of Health regarding the medical care program's operations. Final authority for any action rests with the Commissioner of Economic Security.

The Council is made up of these two Commission-

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ers as ex-officio members; four citizens-at-large, who do not represent any professional or vendor group; and one member each of the Kentucky State Medical Association, the Kentucky Pharmaceutical Association, the Kentucky State Association of Registered Nurses, the Kentucky Dental Association and the Kentucky Hospital Association. The last five members are selected from a list submitted by each organization.

Six Advisory Committees

Kentucky's law also provides for six technical advisory committees to give technical advice and assistance to the Advisory Council. We have technical advisory committees on dental care, drug care, physicians services, hospital care, nursing home care and nursing service, composed of professional people in each field.

With the advice and direction of the Medical Advisory Council, the various technical advisory committees and the staffs of the two State departments, we set up our program's ground rules and decided upon eligibility requirements and benefits to be given. The Kerr-Mills program went into operation in January as scheduled.

As Kentucky's medical care program stands now, it is basically the same as when it started, although several liberalizations have been made. Kerr-Mills in action in 1962 presents these benefits in Kentucky for both Medical Assistance to the Aged and Indigent Medical Care: We offer four categories of assistance —physicians, hospital, dental and pharmaceutical care. In January 1963 we will add nursing home care, making Kentucky one of four states in the nation to offer a fully "comprehensive" program composed of all five medical services.

For physicians' services, our program allows a recipient 12 visits per year, either in the home or office. The doctors receive $3 for office calls, $5 for home calls. When the program began, in 1961, physicians' services were limited to "acute, emergency or life-endangering conditions" only. This restriction has been removed. Also, in the first months of the program, we allowed two visits per month by recipients. This of course, amounts to 24 a year which is more than we now have. However, our reasons for changing the limit to 12 a year were based on recommendations from our physician advisory group. The reasoning of this group was two-fold. First, recipients told they were allowed two visits a month, which could not be carried over into subsequent months if not used, were seeing their doctors primarily in order to get in their two visits. They were not, for the most part, making proper use of the program. On the 12-visit-a-year plan, they are more inclined to conserve their visits for times of serious illness when they will be needed more.

Does Not Allow for Serious Cases

Secondly, our doctor-advisors felt, and I agree, that limiting visits to two a month does not allow for any serious case that might require seeing the doctor several times within a short period. Our Kerr-Mills program, as it stands, makes it possible for a recipient to use all 12 visits during one month if this is necessary. Furthermore, we may extend the number of physician visits in extreme cases. This requires a recommendation from the attending physician and approval from the Commissioner of the Department of Health.

Another change made in the physicians' services phase of Kentucky's program involves the physician's fee. As mentioned previously, we now pay $5 for a home call, $3 for an office call. At the beginning of the program, we paid $3 and $2, respectively. Visits by a physician to a nursing home to see his patient are treated as home calls under Kentucky's program. We do not reimburse our doctors for visits to hospitals or for any treatment in hospitals.

With regard to hospital care, Kentucky's medical program has often been criticized as being too limited in this area. We pay for six days of care per admission. However, let me emphasize "per admission." Conceivably, under our program, a recipient may enter the hospital, complete his stay there, of which we will pay for six days, be readmitted, and we will pay for another six days. We will not tolerate, however, the release and readmittance of a patient simply in order to gain more "paid" days of care. The records are carefully checked by the Health Department, and in a case of this nature we simply would not honor the bill for the second period. On the other hand, the program does allow any number of hospital admissions and this may be either for a recurrence or side-effect of the same illness or for a completely different illness.

Pay Actual Hospital Costs

In addition, I would point out that Kentucky reimburses hospitals on the basis of their actual cost. We pay the hospital's full per-diem cost per day for each of the six days.

Hospitalization, under Kentucky's program is still limited to acute, emergency or life-endangering conditions, including maternity care. The only change made in this—the hospital part of the program—since its inception, is in the number of days per admission. This was increased from three to the present six.

Kentucky's dental services, under the Kerr-Mills Act, are still somewhat limited. At this time we pay for up to $48 a year in dental care. Coverage is limited to services necessary for the relief of pain and treatment of acute infection. This includes extractions with local anesthesia, for which we pay $4 for a single tooth and $2 for each additional tooth at the same visit; x-rays at our rate of $1 for each film; restorations, ranging from $3 to $5 depending on the type; and any other treatment for pain, infection or hemorrhage, for which the payment is $3. Our program is now able to supply preventative dental care, necessary particularly to the Aid to Dependent Children group, or artificial dentures, needed by the aged.

Originally, dental care in Kentucky was limited to the public assistance recipients only. The Medical Aid to the Aged group was added a few months later. Also, when the program began, recipients were allowed only $8 per month of services up to a maximum of $24 a year. When this was doubled, to the present $48 maximum, the monthly limit was removed.

Pharmacy Services

The fourth category of medical services, which Kentucky presently provides, is pharmacy services. This, perhaps, is the most liberal part of the program in terms of benefits to recipients. We pay for an unlimited number of prescriptions so long as doctor or dentist has prescribed them. However, the drugs must appear on a Medical Care Drug List, prepared by the Department of Health. This list contains the generic names of many, many drugs, recommended by the physicians and pharmacists on the advisory committees and throughout the State. They are drugs these people feel are most widely used and needed.

Pharmacists are paid the wholesale cost of the drug plus a $1.10 professional fee per prescription. This reflects a slight change from the program's beginning, when the professional fee was graded according to the wholesale cost. In counties where there is no licensed pharmacy or pharmacist, physicians or dentists are reimbursed at wholesale cost for drugs they dispense.

Medical aid to the aged recipients were also excluded from drug services when Kentucky's program began but added a few months later at the same time they were brought under dental care.

A fifth category of medical services—nursing home care—is to be added in Kentucky January 1, 1963. We have not completed all the groundwork on this program yet, however, I can give a brief description of how it will work. First, Kentucky public assistance recipients have been entitled to nursing home services for several years, on a money payment to the recipient basis. This is one reason for delaying this phase of the program until now. Beginning January 1, however, this service will be provided on a vendor payment basis, which will raise the fee to the home somewhat. MAA recipients will receive paid nursing home care for the first time, this also on the vendor-payment basis.

"High Criteria" Homes

We are in the process of setting up standards for what we term "high criteria" homes. These homes, which will have the highest standards in the State, will be paid on their full per-diem cost. Homes not meeting these standards will receive $125 per month. Unfortunately, in Kentucky, there are only about eight or nine homes which will come under the high-criteria definition. It is hoped that higher payments to them will help raise the standards of other homes.

This, then, is what Kerr-Mills in Kentucky is providing for public assistance and medical assistance to the aged recipients. Now, how is it working in action? To answer this question, let's consider who is eligible for the program and how many are actually receiving help; how the vendor groups are responding to the Kerr-Mills program; how much money is available, how much is spent and how it is being spent.

When Kentucky entered into the Kerr-Mills program in January 1961, there were 143,000 public assistance recipients on the rolls. Of these, more than 55,000 received old age assistance. More than 75,000 were adults and children on aid to dependent children. Nearly 3,000 of the total number were needy blind cases, and about 9,000 were receiving aid to the permanently and totally disabled. These people were all automatically eligible. They comprise the neediest families in Kentucky, unable to provide subsistence for daily living, not to mention money for medical needs.

In addition to this group, we were to give Medical Assistance to the Aged. This would include people over 65 whose income was too high to bring them under public assistance. The size of potentially eligible recipients was unknown. In the State, according to 1960 figures, are more than 292,000 people over the age of 65. Of these, census figures left us with an estimated 87,000 who could potentially meet the standards set for eligibility under Kentucky's program.

Requirements Are Average

Our requirements for eligibility under the MAA program, as they now exist, are about average in comparison with other states participating in the program. They are stricter than in some states, more lenient than in others. To be eligible, a single applicant may have an annual gross income not to exceed $1,200. For a married couple, the income limit is set at $1,800. In Kentucky, homestead property is not taken into consideration. Non-homestead real property may not exceed $5,000. Personal property is limited to $750 for a single person; $1,000 for an applicant and his spouse. Cash surrender value of life insurance is not to exceed $3,000.

Kentucky does not have a provision for recovery of money by means of a property lien or any other method. There is no relative responsibility set forth in our law for Medical Aid to the Aged recipients and there is no deductible clause in the program.

Thus, we feel our eligibility requirements for Medical Aid to the Aged are fairly liberal and that they will qualify people who are actually "medically" indigent as opposed to indigent. That is, MAA recipients in Kentucky are capable of meeting their ordinary living expenses but are not able to cope with the costs of their medical services.

I am aware that there are some areas where the Kerr-Mills program has been criticized because eligibility requirements are so strict they would even eliminate some people who qualify for public assistance relief in these areas. It is also true that some states are transferring their OAA cases to the MAA caseload in order to qualify for higher matching Federal funds.

Neither of these is true in Kentucky. In the latter instance, in fact, the reverse has happened. Many people coming to apply for Medical Aid to the Aged in our offices have found, after investigation, that they are actually eligible for Old Age Assistance and its accompanying monthly subsistence payment. As a result, our OAA rolls have increased since we began medical care, whereas they had previously been on the decline.

Requirements Now More Liberal

Our eligibility requirements are actually a little more liberal now than they were when the program began. At that time, MAA applicants' annual income was limited to $1,000 if single, and to $1,500 if mar-

ried. Liquid assets, or personal property, was limited to $500 for the single applicant, $750 for a married couple. The other requirements were the same.

At any rate, in January 1961 an estimated 87,000 Kentuckians were potentially eligible for Medical Aid to the Aged; 143,000 were already eligible for indigent medical care by virtue of being on the public assistance rolls.

During the first six months of operation, however, the number of statements submitted by the physicians, hospitals, pharmacies and dentists totalled only about 38,000, or an average of about 6,300 a month. This includes both groups of recipients. Thus, out of 231,000 eligible and potentially eligible recipients, less than 6,300 actually received services each month. Probably quite a few less since that figure reflects the total number of statements approved, not people served.

During this same period only about 1,200 MAA applications were taken—this from the estimated 87,000 potentially eligible in Kentucky. At this point we raised the eligibility standards in the hope of attracting more MAA applicants into the program.

Cause of Slow Start

The cause of this slow start can be traced to several factors: A new program, not well known; rather limited services provided; lack of immediate participation by many of the State's vendors; and, of course, not all of those eligible or potentially eligible happened to be in need of medical care at that particular time.

The results of this slow start, however, were rather damaging to the State and to the program. There was much adverse publicity on the failure of the program to attract applicants and to provide more comprehensive services. The most costly result, however, was in terms of money. Because of the low utilization, administrative costs ran extremely high. This cost actually represented a double loss to the State. The Federal government matches benefit costs at a rate of about three to one, while it matches only 50% of administrative costs. Therefore, by putting up more State money for administration than for benefits, Kentucky was actually losing on its investment.

Another financial loss was more obvious and more costly. To finance the medical care program's first six months of operation, through the end of the fiscal year, the State had appropriated $792,000. When matched by Federal funds, the total amount available ran over $6,000,000.

During that six-month period, however, only $78,000 was spent on medical care benefits; less than the State's appropriation alone. Again Kentucky lost Federal funds which should have matched the money that had been budgeted. In addition, nearly $400,000 of the State's appropriation to the medical care program was reverted to the State's general fund for use in other programs.

Thus, money intended for medical care to the State's needy was lost for that purpose. Furthermore, future requests for high appropriations to the program have been difficult to justify.

Fortunately, Kentucky's program has been able to overcome its first six-month difficulties. As the 1962 year is drawing to a close, we have about reached the other end of the scale. Recipients appear to be taking better advantage of the medical care program. Our MAA applications now average about 700 a month and the majority are approved. For example, in October there were 734 applications, of which 653, or better than 88%, were approved.

The total number of vendor statements received for both categories of recipients in October was nearly 75,000. Statements are increasing at the rate of about 2,000 a month. During the first six months of 1962, we approved more than 331,000 statements. In 1961, about 280,000 were approved for the entire year.

These statements, of course, still do not indicate full utilization by the 231,000 potentially eligible recipients. However, it does indicate far better usage of the program than was experienced a year ago.

In addition, we must now look at our finances again. During the past six months, Kentucky has paid an average $400,000 a month for benefits under the Kerr-Mills medical care program. The appropriation for this program for the year is $5,059,450, or roughly $425,000 per month. Thus, our expenses are nearly up with our allotted funds. The addition of nursing home care to the program will probably utilize all the additional money we now have available.

How Kerr-Mills Stands in 1962

This, then, is how Kerr-Mills in Kentucky stands in 1962 in terms of services available, expenditures and utilization. This is a fairly comprehensive program, although still limited in some respects. Four categories of aid are offered, with a fifth to be added in January, but all have some limits as to the amount of care which can be given and the amount of money which can be paid for services rendered.

Utilization, although slow to start, is picking up rapidly but has still not achieved the estimated level we expected. At the same time, our present expenditures are nearly equal with our budgeted resources. If utilization does reach the anticipated high in Kentucky, can the program afford it and still retain the amount and kind of service now given?

Participation by vendor groups in Kentucky has been relatively good, with a few notable exceptions. There are 2,185 physicians, dentists, hospitals and pharmacists participating and submitting statements. These represent at least one service available in 118 of Kentucky's 120 counties. Physicians participate in 115 counties; participating hospitals are located in 69 counties; participating pharmacists cover 104 counties; and dentists participate in 107 counties. In addition, nearly 80 vendors, representing at least six states outside of Kentucky, are participating in and submitting statements to our program.

Kerr-Mills in action in Kentucky in 1962, then, has reached a point of stabilization. There is adequate participation by vendors to permit continued utilization of the program at its present level with some guarantees of freedom of choice to the recipients. Increased utilization of the program coupled with the

(Continued on page 93)

Kentucky's Indigent Medical Care Program

Questions and Answers Regarding MAA and PA Recipients*

Q. How old is the Kentucky Medical Care Program?

A. The Kentucky Medical Care Program began providing benefits on January 1, 1961. Kentucky was the 44th state to adopt a program of vendor payments for medical care provided Public Assistance recipients. Kentucky was, however, one of the first states to provide such benefits to Medical Assistance for the Aged persons.

Q. What is the present extent of beneficiary population?

A. At the present time, there are approximately 152,500 eligible beneficiaries. Most of these are Public Assistance recipients: Approximately 56,000 under Old Age Assistance, 75,000 under Aid to Dependent Children, 8,500 under Aid to the Permanently and Totally Disabled, and 2,000 under Aid to the Blind. The Medical Assistance for the Aged (MAA) category presently has about 11,000 eligible beneficiaries.

Q. How many of Kentucky's elderly citizens can receive care under the program?

A. Counting all of those who are potentially eligible for MAA, it is estimated that over half of Kentucky's citizens 65 years of age or older could receive benefits under the Program.

Q. How do medically indigent elderly citizens become eligible for MAA benefits?

A. They should contact their local county public assistance office. Usually, this determination can be made in less than an hour.

Q. How can a physician know if his patient is eligible for program benefits?

A. Program beneficiaries have all been informed of their eligibility and supplied with identification cards. Current validity of identification cards cannot be assured; a physcian may desire to assure that the certification is valid by contacting the local county public assistance office.

Q. Are there any plans to improve the reliability of the current beneficiary identification system?

A. The administering agencies and the Advisory Council are carefully evaluating the present identification system and hope to make necessary improvements when feasible.

These questions and answers were prepared by William H. McBeath, M.D., director, Bureau of Medical Services, Kentucky State Department of Health, at the request of KSMA's Technical Advisory Committee on Indigent Medical Care.

Q. Has there been widespread participation by Kentucky physicians in the program?

A. Yes. About 1,500 Kentucky physicians from 118 counties have submitted statements to the Program requesting payment for services they rendered eligible beneficiaries. Many others have signed statements for hospital and pharmacy services.

Q. Has the Kentucky State Medical Association supported the program?

A. Yes. In fact, the full cooperation given the Program by organized medicine has doubtless been the significant feature in its continuing development.

Q. If a physician has not participated before, how does he now "sign up" to exercise program benefits for his patients?

A. For physician participation, there is no "sign up." Physicians may begin participation at any time by simply submitting requests for payment on the statement forms supplied by every county health department. Likewise, the physician may cease to participate at any time he chooses.

Q. If a physician is participating, is he required to accept all eligible beneficiaries and submit the bills to the program?

A. No. The physician may accept some patients under the Program's provisions and request other eligible beneficiaries to make financial arrangements for their care outside Program provisions. Likewise, with an individual eligible beneficiary, the physician may choose to charge the Program for certain periods of care while making other arrangements with the patient for different periods of care.

Q. Are out-of-state physicians allowed to participate?

A. Yes, the only requirement being that the physician must be licensed to practice medicine or osteopathy by the state of his residence.

Q. What are the current physician services benefits?

A. Presently, the Program will pay for 12 physician visits per patient per year at rates of $3 for each office call or $5 for each home visit.

Q. Is it true that some recipients are granted extensions above the 12 visits per year?

A. Yes.

Q. How is the request submitted for extended physician visits and on what basis is approval determined?

A. In most instances, the physician is unaware of the number of physician visits the recipient may have accumulated. Therefore, at the present time, when the Program's processing system reveals that the Program is being billed for a thirteenth or subsequent visit on the patient's behalf, the physician is transmitted a letter requesting any additional information necessary for determining approval of extended benefits. Available funds require that extended visits be limited to only a relatively few individuals. It is hoped that county medical review committees can soon be utilized in these determinations.

Q. Will the program allow for two physician visits on the same day?

A. No, except for the most unusual of exceptional cases.

Q. Does the program at present provide payment for surgical services?

A. No. Of course, ambulant surgery in the physician's office is eligible for the $3.00 office call fee. However, there is no additional fee for surgical services.

Q. Does the program at the present time pay for injectables administered in the physician's office?

A. No. The present fee system for physicians does not include an additional amount for injectables provided to patients in the home or office.

Q. May the physician bill the program $3.00 for an office visit and charge the patient extra for special procedures performed?

A. No. The physician is, of course, always free to bill the patient for the total charge in his usual manner if he chooses. However, if the physician elects to bill the Program for any payment, that Program payment must be accepted as full payment for all services rendered that patient on that date.

Q. Are routine physical examinations such as school admission physicals payable under the program?

A. No. Purely preventive services on well patients are usually not payable under the Program. The Program at the present time tends to primarily confine itself to the payment for services involving the treatment of pathological conditions.

Q. Why were influenza immunizations restricted to those beneficiaries who were pregnant or over sixty-four years of age?

A. Financial considerations precluded providing this service to all beneficiaries and it was felt that this group was a population of primary concern, as defined by the Surgeon General.

Q. How soon will all immunizations be payable under the program?

A. It is anticipated that some immunizations will be payable under the Program in 1963 after beneficiaries can currently be provided routine immunization gratis through county health departments.

Q. Are physicians paid anything for services rendered to beneficiaries in the hospital?

A. At the present time, no. This is one of the many areas of the Program which has been severely limited due to lack of funds. These areas are being continually examined in the event that additional funds become available to expand Program provisions.

Q. Are physicians paid anything for services rendered to beneficiaries in nursing homes?

A. Yes. A visit to a patient in a nursing home is considered an eligible home visit.

Q. What does the program pay hospitals for the care of beneficiaries?

A. Hospitals are paid for up to six days of care in the treatment of acute, emergency, or life-endangering conditions. Most of them are paid on the basis of reimbursable cost, others on a flat rate basis.

Q. Are hospitals paid for tonsillectomy and adenoidectomy admissions?

A. Usually not. Hospitalization for tonsillectomy and adenoidectomy are eligible for payment only when the attending physician offers his personal written descriptive justification certifying a bona fide life-endangering, emergency condition (e.g., mitral valve disease) as the indication for surgery. Chronic hypertrophic and recurrent acute tonsillitis with or without otitis are not usually considered life-endangering. This policy also is dictated by limited funds.

Q. Under what conditions will the program pay for hospital readmissions of patients recently discharged?

A. Readmissions are payable only when there has been the reappearance of a bona fide life-endangering emergency situation, which had been previously alleviated by a prior admission. This change of status also must be personally justified by the attending physician.

Q. Are revisions in the medical care drug list really based upon practicing physicians' requests?

A. Yes. The revision of September, 1961, incorporated several such requests and another revision pending for early 1963 will reflect additional changes suggested by participating physicians.

Q. Is it really necessary for the physician's actual signature to appear on each statement?

A. Yes. The prohibition of stamped or delegated signatures is a policy which seems in the best interest of the physician and the Program. The initial months of the Program have already proved the validity of this policy.

Q. How long after services have been rendered may a physician wait to submit his request for payment?

A. Requests for payment must be received within sixty days of the date services were rendered.

Q. Is it absolutely essential that each statement list the patient's diagnosis?

A. On physicians' services statements, a specific diagnosis is essential. On pharmacy services statements (prescription blanks) the physician is requested to enter diagnosis; however, prescriptions not bearing a diagnosis are approved for payment.

Q. How is the Kentucky Medical Care Program financed?

A. The Program's present annual budget (excluding nursing home care) is approximately five million dollars, of which about 75% are Federal funds and the remainder received from State appropriations.

Q. Is it anticipated that physicians services benefits or fees will be increased in the near future?

A. This again is a matter which can only be determined when increased budgetary appropriations are available. The present biennial budget would not allow for such an increase.

Q. To whom may comments or criticisms concerning the program be addressed?

A. Physicians should address such items to either or both of the below listed individuals:

Medical Director
Division of Medical Care
State Department of Health
275 East Main Street
Frankfort, Kentucky

or

Chairman, Technical Advisory
Committee on Physician Services
Kentucky State Medical Association
3232 Janet Avenue
Louisville 5, Kentucky

"In the field of health care, particularly, the quality has gone up so remarkably that, of course, the cost to some degree has gone up; but the net result is that we are getting so much more for our health dollar today than ever before, that one becomes disturbed to hear the attacks made about its cost without reference to its quality. Certainly a bottle of wonder drugs costs $10 today, and one can still buy a bottle of patent medicine designed to cure the same ill for $1. I don't think anyone doubts that for the $10, in a much smaller bottle, one gets a thousand times, not ten times, the health per $1 spent."—*The Hon. Thomas B. Curtis (Rep., Mo.) to Medical and Chirurgical Faculty of the State of Maryland, April 5, 1962.*

ORGANIZATION SECTION

This is the Town and Country Restaurant in Park Hills, Covington, Ky., where the 1963 Interim Meeting of the Kentucky State Medical Association will be held March 7. A story outlining some of the highlights of this meeting is on this page. A program featuring discussion by experts of pertinent and highly important topics related to the profession and the Association promises to make this a truly outstanding session.

Four Additional Speakers Announced for March 7 Interim Meeting; Program Promises Outstanding Presentations for 1963 KSMA Session

Four additional top-notch speakers are announced this week for the Interim Meeting of the Kentucky State Medical Association to be held March 7, 1963, at the Town and Country Restaurant, Park Hills, Covintgon, Ky. President David M. Cox, M.D., Louisville, in making the announcement, said he felt that every KSMA member and every doctor in Kentucky should hear the messages that these experts in their fields will bring.

Those who will address the Interim Meeting, in addition to Milton V. Davis, M.D., Dallas, secretary-treasurer of AMPAC (see The Journal for December 1962), are: Karl C. Jonas, M.D., Philadelphia, Pa., member of the Physicians Review Board, Philadelphia Blue Cross; Ever Curtis, M.D., Gloucester, Mass., general practitioner; Burl S. St. Clair, Falls of Rough, Ky., immediate past president of the Kentucky Farm Bureau; the Rev. Dr. William W. Slider, minister, Christ Methodist Church, Louisville, Ky.

Doctor Jonas will address the session on the topic: "The Relation of the Practicing Physician to Voluntary Health Insurance."

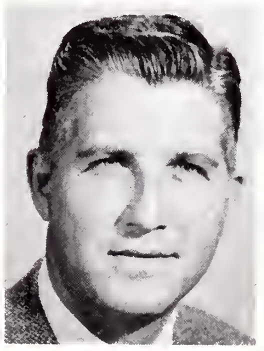
He is a graduate of Duke University School of Medicine in the class of 1944 and interned with the U. S. Naval Hospital, Philadelphia. He served with the Fleet Marine Force for two years—1945-1946.

Doctor Jonas was a fellow in surgery at Temple University School of Medicine and Temple University Hospital in 1946-1948 and took a master of science in surgery degree at Temple in 1949. He is currently director of surgery at Stetson Hospital; chief of surgery at St. Joseph's Hospital and attending surgeon at Pennsylvania Hospital.

Doctor Curtis was one of four panelists on a TV Show, May 23, 1962, who discussed medical care for the aged. She and Norman Welch, M.D., speaker of the American Medical Association House of Delegates, opposed a team which included a former Social Security commissioner. She is currently secretary of the public relations committee of the Massachusetts Medical Society and councilor for that organization. Doctor Curtis is a graduate of Jchns Hopkins University.

She will address the Interim Meeting on the subject: "Who Is Promoting Government-Controlled Medicine?"

Mr. St. Clair, who will address the meeting on



Doctor Jonas

Doctor Curtis

the subject: "Opportunity Versus Security," was elected president of the Kentucky Farm Bureau in 1952. He served as Kentucky Farm Bureau president for 10 consecutive years.

In November 1962 Mr. St. Clair became chairman of the Governor's Commission on Public Education and in 1961 was made a member of the Governor's Constitutional Revision Study Group. He was made a member of the board of directors of Southern States Cooperatives in November 1962.

Doctor Slider's Topic

"PRN (Take as Needed)" will be the subject of the Reverend Doctor Slider. Doctor Slider is noted for civic work in Kentucky and also in Arkansas and Texas. In 1960 he received the American Cancer Society Distinguished Service Medal. He is a member of the board of directors of the School of Handicapped Children; board of directors, American Cancer Society; board of directors, University of Louisville Associates, and is a member of the Mayor's Committee for Religious Affairs in Louisville.

30 Discoveries by Drug Industry in '62, Cited by Dr. Smith

More than 30 major scientific achievements in 1962 were credited to the drug industry by Austin Smith, M.D., president of the Pharmaceutical Manufacturers Association. Doctor Smith spoke at an eastern regional meeting of the Association in New York, December 10.

Among discoveries cited by Doctor Smith were: Three new cancer agents; a life-saving drug for treatment of shock; a semi-synthetic penicillin which controls a variety of penicillin-resistant bacteria; a new and safer inhalation anesthetic; a live measles vaccine; a visual technique for the detection of syphilis; the first organic bone mixture suitable for use in orthopedic surgery. He also cited promising work in basic enzymology, cardiovascular research, laboratory synthesis of steroids and antibiotics, and in the production of vaccines and hormones.

Doctor Smith reviewed the industry's contributions in 1962 to: Development of sound drug control legislation; drug safety; more effective exchange of scientific information; to schools, hospitals, universities, etc. He was critical of the Department of Defense practice of purchasing drugs abroad, and he said a bill to prohibit Government agencies from purchasing drugs from foreign firms that have pilfered U. S. trade secrets, has already been introduced in Congress.

AMA Raises Subscription Prices

Effective January 1, 1963, the American Medical Association has raised the subscription price of the Journal of AMA to $18 per year and the price of its 10 specialty journals to $12. The raise does not apply to dues-paying members. AMA associate members and dues-exempt members still receive the 50% rate.

Kentucky Urological Society To Be 15th KSMA Specialty Group

The Kentucky Urological Society will become the 15th specialty group to conduct a special program during the Annual Meeting of the Kentucky State Medical Association, beginning with the 1963 session. The Society is headed by George A. Sehlinger, M.D., Louisville.

The idea for specialty groups to take charge of a series of afternoon programs during the KSMA Annual Meeting originated in 1954 during the presidency of J. Duffy Hancock, M.D., Louisville. The specialty groups arrange their own programs, select speakers, and members of KSMA attending the Annual Meeting are free to attend any one or more of these technical sessions. Speakers invited by the groups also address one general session of the Association.

When the idea was begun in 1954 there were eight specialty groups which conducted programs. In 1962 there were 14. Beginning in 1963, with the addition of the Kentucky Urological Society, there will be 15 specialty group sessions offering a wide choice of technical information for those attending the KSMA Annual Meeting.

Powell Pays 1963 Dues First

The Powell County Medical Society led all other societies in Kentucky in paying its 1963 dues to the Kentucky State Medical Association and the American Medical Association. The annual report for 1963 from the secretary, J. F. Knox, M.D., Stanton, was received December 4 in the KSMA Headquarters Office.

KSMA President David M. Cox, M.D., Louisville, urged all members to cooperate with their local county society secretaries by sending checks to cover their dues promptly thus making the work easier and taking less time. Doctor Cox said, "Remember, your county society secretary, like you, is busy and he will appreciate your thoughtfulness."

Extended Servicemen Released

An article in the December 1962 issue of The Journal of the Kentucky State Medical Association stated that a number of servicemen had been retained on active duty past their expiration date, and that dependents of these servicemen did not have a current privilege card.

The Journal has since learned that these extendees have been released from active duty. Where I D cards have expired or were never issued for dependents of these servicemen, physicians or hospitals may accept copies of discharge reports (DD Forms 214), official orders or other official documents (which establish the sponsors' active duty period) in lieu of valid DD Forms 1173. Of course, prior to payment of any claim requiring this type of documentation, care should be exercised to insure that the claim is complete and payable from all standpoints other than the I D card requirement.

Three More Auto Safety Awards Presented by KSMA

Two major taxicab companies and a sportscar association were presented automotive safety awards at a luncheon meeting Tuesday, December 18, at the Headquarters Building by the KSMA's Committee on Highway Safety for their successful effort in installing seat belts in all automobiles operated by their organizations. (See picture on this page.)

The committee highly complimented John Beard, president of the Louisville Taxicab and Transfer Company, and Roy Fleischman, president, B-Line Cab Company, for their outstanding leadership in bringing this safety feature to public conveyance vehicles. John Hislop, regional executive director of the Sports Car Club, accepted the award for his organization.

For an organization to be a recipient of the award it must have 100% seat belt installation in every car operated by its membership. The Committee cited these organizations for their thoughtful planning for the protection of automobile passengers and the public and pointed out that Louisville was the third city in the nation that had taxicab companies install seat belts in all of their vehicles.

The Kentucky State Medical Association recognizes and commends these organizations not only for active concern over the survival for their own members and families, but their leadership and the example they set to all people.

Mrs. Ralph Writes Article

Mrs. Ann Stokes Ralph, Lyndon, Ky., president of the Kentucky Association of Nursing Homes, has written an article, "Institutional Care of the Aged," which appears in the December 1962 issue of *Nursing Homes,* official journal of the American Nursing Home Association.

Doctor Chatham Named Trustee To Succeed Doctor Norvell

Donald Chatham, M.D., Shelbyville, was named seventh district trustee of the Kentucky State Medical Association at the December 13 meeting of the Board of Trustees, to succeed Wyatt Norvell, M.D., New Castle, who resigned following his naming as delegate to the American Medical Association from KSMA.

Following the provisions as set forth in Chapter VI, Section 8, of the KSMA Constitution and Bylaws, the Board polled the delegates of the district and named Doctor Chatham to serve as trustee until the next meeting of the House of Delegates.

Doctor Chatham, a general practitioner, is a 1952 graduate of the University of Louisville School of Medicine and is prominent in the community and civic affairs of his town as well as in medical association activities. He is president of the Alumni Association of Georgetown College.

Medical Care for the Aged

The following portion of the 1962 report of the Committee on Aging of the Kentucky State Medical Association, which was approved by the House of Delegates at the 1962 Annual Meeting, is published at the recommendation of the Executive Committee.

"With medical care for the aged still commanding a large share of the spotlight on the national legislative scene, it is the opinion of this Committee that, in keeping with American traditions, it is first the primary responsibility of the individual in providing for his medical care as well as other personal care. When the individual is unable to provide this care for himself, the responsibility should rightfully pass to his family, then to the local community, county and state, and all in that order. Then, and only then, should the federal government assume a role, and then only in cooperation with the other governmental bodies heretofore cited."

Members of KSMA's Highway Safety Committee and representatives of organizations receiving automotive safety awards are pictured above. (See story on this page.) Seated left to right: Joseph Snowden, Sportscar club; John Robbins, M.D., committee member; J. R. Sclarenco, Louisville Taxicab and Transfer Company; Arthur H. Keeney, M.D., committee chairman. Standing: Denver Cornette, John Hislop, and William Gossman, Sportscar club; Arthur James, Louisville Taxicab and Transfer Company; William Keller, M.D., committee member, and Roy Fleischman, B-Line Cab Co.

Greenville Kiwanis Club Honors Gaithel L. Simpson, M.D.

Gaithel L. Simpson, M.D., Greenville, immediate past president of the Kentucky State Medical Association, was honored in a resolution passed September 27, 1962, by the Greenville Kiwanis Club.

The resolution noted particularly the contribution of Doctor Simpson in construction of the Muhlenberg Community Hospital; his efforts in relation to the program for construction of state-maintained institutions for the treatment of tuberculosis; his recognition by the Kentucky Chapter, American Cancer Society for his contributions to their program, and his efforts which promoted adoption by the State of Kentucky of a workable program for medical care to the medically indigent.

Noting his service as president of KSMA and several contributions outside the field of medicine, the resolution extended congratulations to Doctor Simpson on "the several honors and recognitions that have come to him because of his illustrious career in the fields of medicine and surgery," and its appreciation for his many services for his community, county and state.

Los Angeles AMA Session Is Well-Attended

Physician registration at the 16th Annual clinical meeting of the American Medical Association totaled 5,209 making it the largest clinical meeting in AMA history. The meeting was held at Los Angeles, November 25-28. In 1951 when the session was also held at Los Angeles, physician attendance totaled 4,969. Total attendance at the 1962 meeting—10,908.

Topic Highlights

Topic highlights of the program included: Air pollution, cancer, aerospace medicine, muscular dystrophy, hepatitis, viruses, aging and suicide prevention.

A series of 21 medical motion pictures were presented as part of the scientific program, including films showing interior views of the stomach photographed with a recently developed instrument called a fibroscope; a film on emergency childbirth with live action footage of actual deliveries; films on cerebral vascular disease; cystic fibrosis; acute head injury and the cough.

Color Telecasts

Other features of the scientific sessions included three closed-circuit color telecasts dealing with "Ulcerative Colitis and the Ileostomy Problem"; "Management of the Abnormal Cervix" and "Tumor Clinic."

U. S. Senator Carl T. Curtis, Republican of Nebraska, addressed the fifth annual Medical Services Conference, November 25, saying that a "real fight" will have to be made to preserve the private practice of medicine.

"I believe we can win that fight," he said, "and I believe we can win it in 1963."

The Fourth National Conference on the Medical Aspects of Sports was held Sunday afternoon, November 25, and highlighted contact sports, track and field, competitive sports for children and adolescents, and water sports. The program included a symposium on injuries to the extremities and demonstrations of rehabilitation exercises and of bandaging and taping for prevention and treatment of injuries.

At the opening session of the meeting, devoted to air pollution, A. J. Haagen-Smit, Ph.D., California Institute of Technology, said exhaust control devices on automobiles alone will not solve the smog problem in such cities as Los Angeles. He said a broader approach to the problem is necessary.

Research experiments in muscular dystrophy made at Northwestern University Medical School were reported to the meeting, suggesting prospects for a longer and more active life for muscular dystrophy patients and the possibility that the disease may be a disorder of metabolism.

Problems of the Aging

A mock hearing, with interrogator and witnesses, presented the problems of the aging to the Scientific Assembly on November 27. The sum total of the "testimony" indicated that problems of the over-65 age group differ from those of other segments of the population only as these people are affected by compulsory retirement.

The AMA's Committee on Aging reported on the results of its seven-year study saying that, "compulsory retirement is a waste of human resources that this nation can ill afford . . . it contributes measurably to ill health resulting from lack of work, exercise and responsibility." A report on the meeting of the AMA House of Delegates and activities of the Kentucky delegation at the clinical meeting is on page 64.

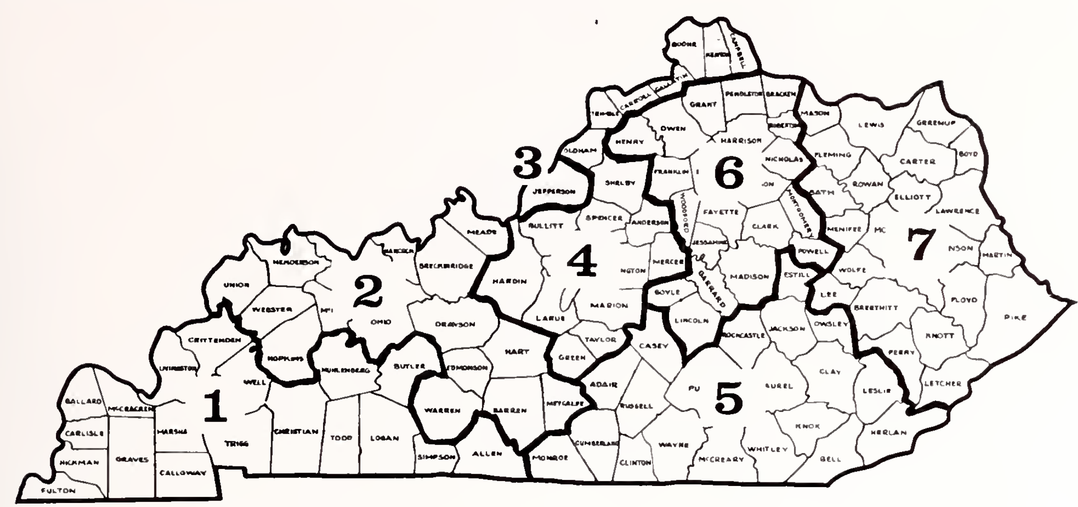
The presentation made by Earle V. Powell, commissioner, Kentucky Department of Economic Security, before the Medical Services Conference, which outlined how Kerr-Mills works in Kentucky, is on page 50.

Among those attending the AMA meeting from Kentucky were:

Thomas H. Biggs, M.D., London
Robert H. Cofield, M.D., Covington
Carl C. Cooper, Jr., M.D., Bedford
David M. Cox, M.D., Louisville
M. R. Cronen, M.D., Louisville
J. Thomas Giannini, M.D., Louisville
John C. Hill, M.D., Louisville
Wolfgang Hoelscher, M.D., Louisville
Robert C. Long, M.D., Louisville
Owen B. Murphy, M.D., Lexintgon
Wyatt Norvell, M.D., New Castle
J. Vernon Pace, M.D., Paducah
John C. Quertermous, M.D., Murray
W. B. Stewart, M.D., Lexington
Thomas D. Vance, M.D., Middlesboro
Harry E. Voyles, M.D., Louisville
John P. Welborn, M.D., Morganfield
William R. Willard, M.D., Lexington
Carroll Witten, M.D., Louisville

KNOW YOUR CONGRESSMEN

Present Seven Congressional Districts



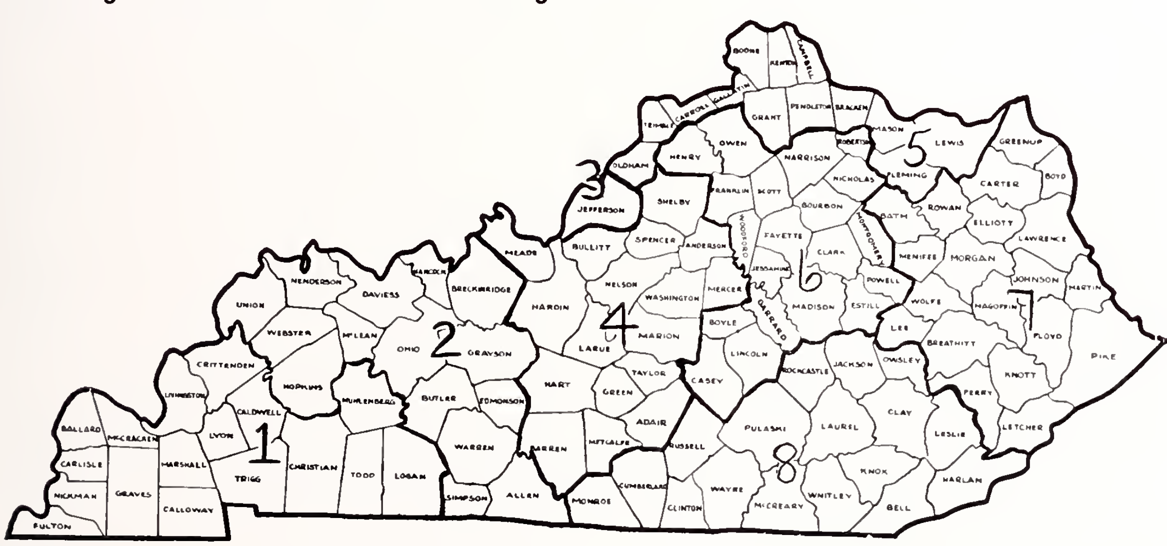
The two maps on this page show the effect on Kentucky of the redistricting which was done by the 1962 Kentucky General Assembly as a result of the 1960 census and which reduced the number of Congressional Districts and hence the number of Kentucky Congressmen from eight to seven.

It is important that all members of the Kentucky State Medical Association and all physicians in the State of Kentucky become familiar with the Districts in which their counties are located and know the names of their Congressmen. Important legislation affecting the practice and lives of physicians as well as all other citizens of the State and of the Nation will be considered during the present Congressional session and your Congressman will want to know your thinking and opinions on such matters.

Kentucky's two senators, John Sherman Cooper, Rep., Somerset, and Thruston B. Morton, Rep., Louisville, represent your State in the U. S. Senate.

Kentucky's seven Congressmen, their parties, districts and home towns are, as follows: First district, Frank A. Stubblefield, Dem., Murray; second district, William H. Natcher, Dem., Bowling Green; third district, Gene Snyder, Rep., Louisville; fourth district, Frank L. Chelf, Dem., Lebanon; fifth district, Eugene E. Siler, Rep., Williamsburg; sixth district, John C. Watts, Dem., Nicholasville; seventh district, Carl D. Perkins, Dem., Hindman.

Old Congressional Districts Before Redistricting



Sixth Trustee District Society Elects Doctor Keen

Harold Keen, M.D., Bowling Green, was elected new president of the Sixth District Medical Society at a meeting November 15 at Glasgow. John C. Ayers, Jr., M.D., Cave City, was elected vice president and Paul J. Parks, M.D., Bowling Green, secretary-treasurer.

A program on the diagnosis and treatment of low back symptoms was presented by O. James Hurt, M.D., and Wayne W. Kotcamp, M.D., Louisville orthopedic surgeons.

Doctor Dickinson Presides

John Dickinson, M.D., Glasgow, president of the Society, presided over the business session which preceded the program presentation. C. C. Howard, M.D., Glasgow, president of the Barren County Medical Society, was recognized, as was John P. Glenn, M.D., Russellville, trustee of the Sixth District.

L. M. Wilson, M.D., Bowling Green, member of the House of Delegates of the Kentucky State Medical Association, reported on the redistricting plan at the meeting and the Society went on record as opposed to changing the present Sixth Trustee District.

American College of Physicians Names Fellows, Associates

The following from Kentucky were elected to the American College of Physicians in November 1962, according to the report of Sam A. Overstreet, M.D., Louisville, governor for the Kentucky Chapter:

Named Fellows were: Irving F. Kanner, M.D., Lexington; Albert C. Goldin, M.D., Carroll H. Robie, M.D., and Sidney Roston, M.D., all of Louisville; William Petrie Hall, M.D., Paducah.

Named Associates: James Elliott Bryan, M.D., Jerry Milton Shaw, M.D., and Will Walker Ward, Jr., M.D., all of Louisville; James Duggan Evans, M.D., Paducah.

Surgeons To Meet Mar. 18-19

The 31st annual assembly of the Southeastern Surgical Congress will be held at Miami Beach, Florida, March 18-19. Among Kentuckians who will participate in the program are: John H. Jurige, M.D.; Thomas E. Booth, M.D.; Charles F. Wood, M.D., and R. Arnold Griswold, M.D.—all of Louisville, and Merrill W. Schell, M.D., Owensboro.

A meeting for registered nurses will be held at the same time.

Heart Symposium March 27-28

The ninth annual Symposium on Cardiovascular Diseases, sponsored by the Heart Association of Louisville and Jefferson County and the University of Louisville School of Medicine, will be held March 27-28, 1963, at the Brown Hotel, Louisville. Grover B. Sanders, M.D., Louisville is chairman. The program for the meeting will appear in the February issue of the Journal.

Sears-Roebuck Foundation, SAMA To Offer Preceptor Program

For the second consecutive year, the Sears-Roebuck Foundation and the Student American Medical Association will sponsor a preceptorship program to acquaint medical students with general practice in small communities.

It was announced by James T. Griffin, Foundation president, and Russell Staudacher, SAMA executive director, that 10 preceptorships would be granted in 1963 to junior and senior medical students who spend two consecutive months with physicians in communities which have built medical centers under the Foundation's medical assistance program. Each preceptor will receive a $500 scholarship and the community in which he works will provide his room and board. Interested students may submit applications, available through SAMA chapters, to the executive director of SAMA in Chicago.

At the 18th meeting of the Medical Advisory Board to the Foundation, November 24 at Los Angeles, Norman H. Davis, secretary, said that as of that time 81 medical centers had been constructed. The preceptorship program was discussed at the Board meeting by a student and by a physician.

Health Department Report for '61-62

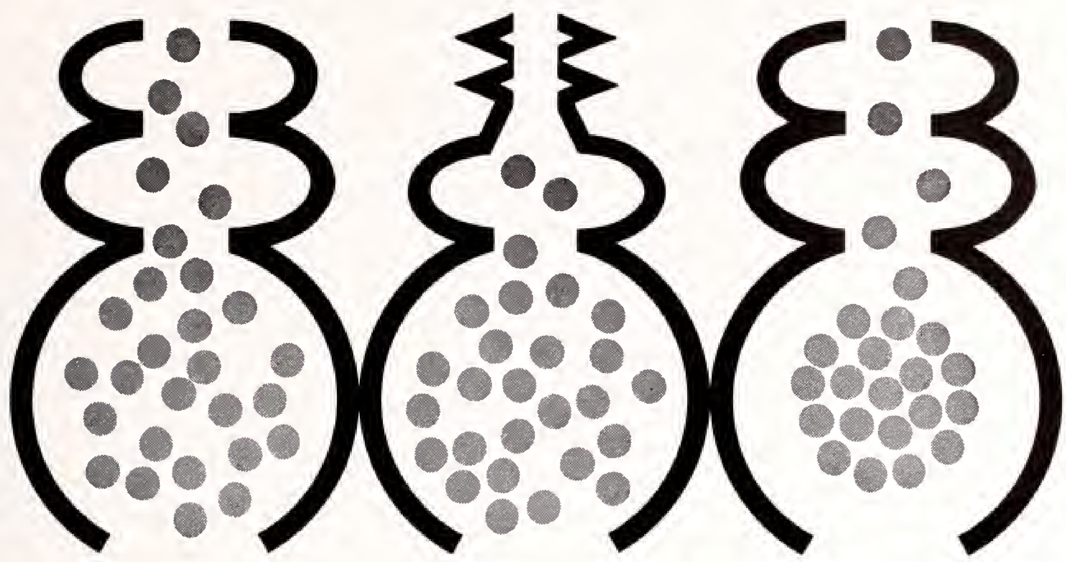
Over 500,000 statements totaling $3,500,000 for health services for needy Kentuckians under the medical care program were approved by the Kentucky State Department of Health during the fiscal year 1961-62, according to the annual report of the Department.

Among other accomplishments in the period, according to the report, are: Pediatric clinics in eastern Kentucky; assistance to Kentucky nursing and personal care homes; a junior sanitarian program for school children; screening tests for glaucoma; a program for testing new born babies for phenylketonuria. Under the Hill-Burton program, the report said, three new public health centers were completed in the State as was a nursing home at Covington and five additions to existing hospitals were made possible.

Allied Council Elects Officers

Wyatt Norvell, M.D., New Castle, was succeeded as chairman of the Allied Council on Medical Services by Vincent Barr, D.D.S., Frankfort, at a meeting of the Council December 3. Doctor Norvell had served two terms as chairman. Other officers named: Vice chairman, Hasty W. Riddle, Louisville, executive secretary of the Kentucky Hospital Association, and secretary, Bobbie R. Grogan, director of field services for the Kentucky State Medical Association.

A West Indies health care plan, established in 1956 and operating as a voluntary health care program, has been accepted as an affiliate of the National Association of Blue Shield Plans. It has 11,000 members. This brings to 76 the number of Blue Shield plans and affiliates in the National Association.



lowers motility | relieves cramping | stops diarrhea

LOMOTIL® Antidiarrheal tablets and liquid

(brand of diphenoxylate hydrochloride with atropine sulfate)

Traditionally the most effective means of slowing excess intestinal motility in diarrhea and so of relieving the disorder have been the opium derivatives. Now Lomotil makes available an antidiarrheal agent[1] of greater therapeutic efficiency than morphine.

By controlling hypermotility, the basic mechanical dysfunction of diarrhea, Lomotil reduces the frequency and fluidity of stools, diminishes cramping and controls diarrhea in many patients in whom other drugs have proved inadequate.

In a recent clinical report Cayer and Sohmer[2] state: "The alleviation of symptoms [with Lomotil] was usually prompt, occurring within 24 to 72 hours even in the long-standing chronic cases. . . . A surprisingly satisfactory response was obtained in 75 per cent of the patients with regional enteritis and in 63 per cent of those with ulcerative colitis, all of whom had failed to respond to other measures."

The high therapeutic efficiency of Lomotil, its safety, convenience and economy may be used to advantage in acute or chronic diarrhea.

Dosage: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily. Maintenance dosage may be as low as two tablets daily.

Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

Note: Lomotil is an exempt preparation under Federal narcotic statutes.

Detailed information and directions for use in children and adults are available in Physicians' Product Brochure No. 81. G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholino-Butyrylpyrrolidine and Related Amides. I. Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. 9:381-400 (June) 1957.
2. Cayer, D., and Sohmer, M. F.: Long-Term Clinical Studies with a New Constipating Drug, Diphenoxylate Hydrochloride, N. Carolina Med. J. 22:600-604 (Dec.) 1961.

G. D. SEARLE & CO. *Research in the Service of Medicine*

Graduate Medical Education, Health Care for Aged, Ethics and Enlarged Board of Trustees Considered at AMA Session

MAJOR subjects considered in a well-attended and very active meeting of the American Medical Association's House of Delegates at the Interim Meeting in Los Angeles, November 25-28, included: Graduate medical education, health care for the aged, physician ethics, enlargement of the Board of Trustees and the many highly important miscellaneous matters.

KSMA Delegates Present

The Kentucky State Medical Association's three delegates—Robert C. Long, M.D., Louisville; J. Vernon Pace, M.D., Paducah, and Wyatt Norvell, M.D., New Castle—along with the three alternates—John C. Quertermous, M.D., Murray; Thomas J. Giannini, M.D., Louisville, and Carl C. Cooper, M.D., Bedford—were present at all meetings.

Sitting in on the KSMA's delegation's caucus and attending meetings of the House and Reference Committees were President David M. Cox, M.D., Louisville, and President-Elect George P. Archer, M.D., Prestonsburg, along with KSMA members including Dean William R. Willard, M.D., of the University of Kentucky Medical Center, Lexington.

The House unanimously approved the address of AMA President George M. Fister, M.D., when he said:

"We will not compromise on the fundamental principles in which we believe and for which we have fought in the past with courage and good judgment. We will not jeopardize our position either by indicating a willingness to consider a compromise which would damage our basic principles, or by hasty action which might be misinterpreted."

Reaffirm Kerr-Mills Support

The House reaffirmed, without compromise or change, the Association's present policy of opposition to the King-Anderson type of legislation and support for the Kerr-Mills program. In so doing, it also approved in principle the following suggested amendments to the Kerr-Mills Law:

1. Remove the requirement that both Old Age Assistance (OAA) and Medical Assistance for the Aged (MAA) programs be administered by the same agency;

2. Provide flexibility in the administration of the income limitations proposed under state law so that a person who experiences a major illness may qualify for benefits if the expense of that illness, in effect, reduces his money income below the maximum provided;

3. Include a provision in the law requiring state administering agencies to seek expert advice from physicians or medical societies through medical advisory committees; and

4. Provide for "free choice" of hospital and doctor under state programs.

At the same time, the House also endorsed in principle four proposed amendments to the Internal Revenue Code, designed to assist in financing the medical and hospital expenses of the aged. These amendments would: liberalize tax deductions for medical expenses of dependents over age 65; remove the 1% drug limitation and include drugs as medical expenses; permit taxpayers over age 65 to receive full tax benefit for medical expenses by use of the carry-forward and carry-back principle, and provide a tax credit for medical expenses paid by the over-age-65 taxpayer, proportionate to the relation between his medical expense and taxable income.

Status Report Approved

The House also approved a status report which concluded with this statement:

"It is our strong conviction that the legislative situation, the expanding health insurance and prepayment coverage, the improving economic status of the aged, and the many other factors cited in this report require that we face the 1963-1964 Congressional campaign without defeatism or complacency and with pride in the progress that has occurred. Finally, it is, above all, essential that our position not be undermined by the adoption of any policies that compromise our basic principles."

In considering seven so-called "pledge" resolutions, involving professional freedom, the House adopted a substitute resolution urging that all physicians be encouraged to support the position taken by the House of Delegates in June 1961. That policy statement said, in part:

"The House of Delegates believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay, and it further believes that the profession will render that care according to the system it believes is in the public interest and that it will not be a willing party to implementing any system which is detrimental to the public welfare."

Medical Ethics

The Judicial Council submitted a report containing new opinions on the medical ethics involved in physician ownership of drug stores, drug repackaging houses and drug companies; dispensing of glasses by ophthalmologists, and advertising practices of medical laboratories. The House decided that the questions of physician ownership of drug stores, drug repackaging houses and drug companies, and the dispensing of glasses by ophthalmologists, should not be acted upon at this time. Those opinions were returned to the Judicial Council for further study and report.

The House approved the portion of the report relating to advertising practices of medical laboratories and agreed that the propriety of such practices should be determined at the local level in compliance with the new opinion. The House also approved the

rules of procedure adopted by the Judicial Council for disciplinary action in cases where the Association now has original jurisdiction as conferred by the June 1962 change in the Bylaws.

A special report on the compensation of interns and residents, which was published in the October 27 issue of JAMA, was presented to the House by the Council on Medical Education and Hospitals and the Council on Medical Service. The report was submitted as information only, with a request for further study, comments and suggestions. The House urged that all delegates, hospital staffs and medical societies discuss the report and forward all suggestions to the two Councils in time to influence the form of the report to be presented for action at the June 1963 meeting.

In another action on graduate medical education, the House approved a report on internships and hospital services in which the Council on Medical Education and Hospitals recommended numerous changes in the Essentials of an Approved Internship. The House declared that "their acceptance will further strengthen the educational values of the internship and advance Amercian medicine's contribution to worthy goals of international educational exchange."

House Modifies Recommendation

The House modified one Council recommendation to read as follows:

"In order to maintain high standards of education and better assure the patients' welfare, at least 25% of the total house staff (interns and residents) of a hospital should be graduates of accredited United States or Canadian medical schools. When United States and Canadian graduates represent a lesser portion of the house staff for two successive years, this will warrant that serious consideration be given to disapproving the internship."

The House instructed the Council on Medical Education and Hospitals to exert every possible effort and influence so that all hospitals with approved house officer training programs accept a reasonable number of foreign medical school graduates.

The House, by a vote of 130 to 48, adopted changes in the Constitution and Bylaws which would have implemented the June 1962 recommendations of the Ad Hoc Committee on the Board of Trustees, including expansion of the Board from 11 to 15 members. However, the Judicial Council later informed the House that the affirmative votes necessary to amend the Constitution should have totalled at least 144, or two-thirds of the 216 voting delegates registered at the Wednesday session.

The House then adopted a motion to vote on the proposed Constitutional amendments, in accord with the changes made in the Bylaws, at the opening session of the June 1963 meeting.

A report by the Committee to Study the Scientific Sections, recommending major changes in the organizational structure and scientific program of the Association, was presented to the House by the Board of Trustees. However, because of many requests for delay in approval, the House instructed the Speaker to appoint an Ad Hoc Committee composed of members of the House, and including representatives of the sections, to study the subject and report next June.

Miscellaneous Actions

In considering a wide variety of resolutions and annual and supplementary reports, the House also:

Instructed the Board of Trustees to use every influence in their command to have the *Hill-Burton Law* amended in such a manner as to eliminate all categorical grants; eliminate the term "diagnostic and treatment centers" from any listings in the act, and prevent federal funds being awarded under existing law as a grant to closed panel medical corporations to build diagnostic and treatment centers.

Urged state and county medical societies to continue promoting the aggressive, consistent development of *Blue Shield* senior citizen programs.

Encouraged medical societies and physicians to provide cooperation and leadership in the formulation and operation of regional *hospital planning* bodies.

Recommended that a Board report and two resolutions dealing with the *"Liberty Amendment"* be re-referred to the Council on Legislative Activities for further study.

Warned against the dangerously low level of immunization for *smallpox* and urged physicians and their patients to maintain the needed protection.

Pointed out that state and county medical societies should collaborate with departments of *public health* in the interest of community health, always keeping in mind the need for a proper balance between local public health programs and the private practice of medicine.

Instructed the Board of Trustees to study the feasibility of *regional clinical sessions*, taking into consideration the already established regional meetings of medical specialty groups and the Academy of General Practice.

Commended the Council on National Security and its Committee on *Disaster Medical Care* for initiating a visitation program with committees on emergency medical service of state medical societies.

Opening Session

The delegates learned from a report by the American Medical Association Education and Research Foundation that one out of every ten medical students in the U. S. is now benefiting from the new student loan program. Since its inception nine months ago, the program has granted loans totaling more than $9,000,000 to 3,042 medical students and 1,787 interns and residents, with applications being received at a rate of 150 per week.

It also was announced that Merck Sharp & Dohme pharmaceutical company is making a second matching grant of $100,000 in support of the loan fund. The AMA-ERF also received contributions totaling $440,-583 from physicians in five states for financial aid to medical schools.

Registration

Final registration at the meeting reached a total of 10,908, including 5,209 physicians. (See story on page 60.)

Compulsory Immunization Cited

At a recent meeting of the American Association for the Surgery of Trauma, William T. Rumage, M.D., Louisville, cited the passage at the 1962 Kentucky legislative session of the bill requiring compulsory immunization for pre-school children. In the course of his remarks, he said: "During the past year, the children of the Commonwealth of Kentucky have been blessed by a piece of legislation which has been passed requiring that all children before they enter the first grade, must present a certificate indicating that they have been immunized not only against small pox, but diphtheria, whooping cough, poliomyelitis, and tetanus as well. This legislation was sponsored by Mitchel Denham, M.D., of Maysville, Ky.

"Subsequently, we expect that as our children mature they should be protected against tetanus, if proper booster injections are given. Such widespread immunization has long interested the Trauma Committee of the American College of Surgeons. If such legislation can be passed in our State, you should try to do it in yours."

Mental Health Dept. Reports

Among accomplishments of the Kentucky Department of Mental Health during the fiscal year 1961-62, as reported by Commissioner Harold L. McPheeters, M.D., were the following:

For the fifth consecutive year a decrease in resident population at the State's four mental hospitals; an increase of 50 cents spent per day per patient to $4.96 for the year "still below the national average and still insufficient for an outstanding hospital program"; a guardianship section established to enable the Department to act as guardian for home-going patients with no one else to act in that capacity and establishment of four new outpatient aftercare clinics at Hazard, Henderson, Owensboro and Paducah.

KSMA Reports New Members

Among physicians who have recently joined the Kentucky State Medical Association are the following, all of Louivsille: Herbert Brizel, M.D.; Melvin L. Goldsmith, M.D.; Coleman M. Young, M.D.; John Donald, M.D.; Clifford Berner, M.D.; A. B. Ortner, M.D.; R. D. B. Williams, M.D.; Joseph Dew, M.D., and Veryl F. Frye, M.D.

Others who have joined are: W. C. Morris, M.D., Bowling Green; James Ford, M.D., Carrollton; Ralph T. Ballard, M.D., Harrodsburg, and Jerald E. Adams, M.D., Shelbyville.

General Practice Course Planned

The Cleveland Clinic Educational Foundation, Cleveland, Ohio, formerly the Frank E. Bunts Education Institute, will conduct a postgraduate continuation course, "General Practice" sponsored by the Cleveland Chapter of the American Academy of General Practice, February 6-7, 1963. For additional information, write Walter J. Zeiter, M.D., director of education, 2020 E. 93rd St., Cleveland 6, Ohio.

Student AMA

University of Louisville

Memorial to Doctor Cole

The students at the University of Louisville have planned a program early next month honoring the late Arch E. Cole, Ph.D. Doctor Cole, professor of anatomy for 33 years at the U. of L. School of Medicine, was involved in a fatal automobile accident on July 13 of last year.

Upon recommendation by the Executive Council of the student body, the Medical Council has agreed to dedicate the gross laboratory of the U. of L. as a memorial to Doctor Cole. The present gross laboratory and the future one are to be commemorated in his name, "Arch E. Cole Memorial Laboratory."

The memory of Doctor Cole will long remain in the minds of those who knew him. To these fortunate ones, he was an unselfish man, dedicated to teaching, devoted to his students and enthusiastic in everything he did.

In both the lecture room and laboratory, his students knew him as a thorough and demanding teacher, yet a fair and understanding man. He taught with the zeal of a young man about to embark on an adventurous journey. He instilled in the minds of his students a desire for knowledge and this knowledge he so freely and energetically provided.

We feel that this commemoration is but a very small gesture for a man who has left so much in the minds and hearts of so many.

Jerry B. Buchanan, President
U. of L. Chapter, SAMA

Markle Foundation Reports

The Markle Foundation will continue indefinitely its 15-year program to aid young teachers and investigators on medical school faculties, according to John M. Russell, president of the Fund, in the annual report. Since 1948, he pointed out, over 330 Markle scholars on staffs of 80 medical schools in the United States and Canada have been aided, he said.

Kentuckians, who have been, or are Markle scholars include: Frank Falkner, M.D.; J. Alex Haller, Jr., M.D.; Charles J. McGaff, M.D.; Hubert C. Pirkle, M.D.; Beverly T. Towery, M.D.—all of the University of Louisville School of Medicine; Rene J. Menguy, M.D.; Frank C. Spencer, M.D., University of Kentucky College of Medicine.

SMA Section To Meet Nov. 18-21

The Section of Ophthalmology and Otolaryngology of the Southern Medical Association will hold its next meeting November 18-21, 1963, at New Orleans, La. Papers will be accepted for consideration prior to May 15, 1963. A title and brief abstract of 75 words or less should be sent as soon as possible to the secretary, Albert C. Esposito, M.D., 1212 First National Bank Bldg., Huntington, W. Va.

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KSMA Council and Committee Reports

Council on Scientific Assembly

David M. Cox, M.D., Chairman

KSMA Headquarters, Louisville **November 8**

The Council on Scientific Assembly of the Kentucky State Medical Association, with President David M. Cox, M.D., Louisville, chairman, presiding, met November 8 at the KSMA Headquarters Building at Louisville to outline plans for the 1963 Annual Meeting.

The Council discussed the general format for the meeting which will be September 24-26 at Lexington. All indications are that the 1963 meeting will be an outstanding session.

The Council proposed and set up a meeting for presidents of specialty groups who will hold sessions during the 1963 Annual Meeting. The meeting of the latter was set for December 20 at Lexington.

Scientific Program Committee

E. D. Pellegrino, Chairman

KSMA Headquarters, Louisville **November 15**

Broad plans were laid for the scientific program of the 1963 Annual Meeting of the Kentucky State Medical Association at the meeting of the Scientific Program Committee at the KSMA Headquarters Office Building, November 15. Edmund D. Pellegrino, M.D., Lexington, chairman of the committee, presided at the session.

Among items considered for the annual session, which will be held at Lexington, September 24-26, is the use of color TV. Robert Reath of Smith Kline & French, Philadelphia, was present at the Committee meeting and brought the equipment which would be used for a color TV broadcast.

Preliminary program outlines promise many outstanding features for the KSMA 1963 Annual Meeting. Many broad subjects will be considered in depth, as at the 1962 Annual Meeting last September.

Council on Legislative Activities

John Quertermous, M.D., Chairman, National Affairs
Robert D. Shepard, M.D., Chairman, State Affairs

KSMA Headquarters, Louisville **December 5**

The Council on Legislative Activities of the Kentucky State Medical Association met at the KSMA Headquarters Office Building at Louisville, December 5. Members were told that resolutions introduced during the 1962 KSMA House of Delegates meeting pertaining to the Council have been or are in the process of being disposed of as directed by the House.

Doctor Quertermous, National Affairs chairman, who presided at the meeting, gave a brief but inclusive legislative report on the 1962 American Medical Association interim meeting at Los Angeles.

Congressional District legislative key men were nominated for 1963 and the following names by districts recommended to the Board of Trustees, who approved the list at its December 13 meeting:

G. L. Simpson, M.D., Greenville, First District
D. C. Bennett, M.D., Owensboro, Second District
Homer Martin, M.D., Louisville, Third District
Fred C. Rainey, M.D., Elizabethtown, Fourth District.
Willard Buttermore, M.D., Corbin, Fifth District
J. C. Cantrill, M.D., Georgetown, Sixth District
Charles C. Rutledge, M.D., Hazard, Seventh District.

Several items of importance relating to state legislation were discussed, such as governor, senator and representative candidates; reapportionment of senate and representative districts; emergency aid stations for legislators, and possible introduction of Good Samaritan legislation.

Technical Advisory Committee on Indigent Medical Care

Clyde C. Sparks, M.D., Chairman

Lexington **November 1, 1962**

KSMA's Technical Advisory Committee on Indigent Medical Care met in Lexington, November 1, 1962, with Chairman Clyde C. Sparks, M.D., presiding.

The Committee first considered Pike County Resolution N and Warren County Resolution O which were introduced at the 1962 session of the KSMA House of Delegates. Since Resolution N was referred to the Council on Medical Services by the Executive Committee of the KSMA Board of Trustees, this item was considered only for information.

Resolution O, recommending adjustments in Kentucky's Kerr-Mills program by the administering agencies, was considered at length. Because this Resolution has five parts and some of them dealt with information unknown to the Committee, it was decided that there should be further investigation and consideration.

William McBeath, M.D., director of the Division of Medical Care of the State Department of Health, asked advice from the Committee on various decisions he would have to make pertaining to physician vendors. Since there have been some irregularities in the Program, mostly due to misinterpretations of the regulation, the Committee asked that questions and answers relating to the Program be published in the January issue of The KSMA Journal (See page 54.)

Committee on Third Party Medicine

J. S. Harter, M.D., Chairman

Hospital Committee

J. B. Holloway, M.D., Chairman

Lexington **November 8, 1962**

A joint meeting of KSMA's Committee on Third Party Medicine and its Hospital Committee was held in Lexington November 8.

The purpose of the meeting was for members of each committee to hear individuals discuss disposition of the UMWA Hospitals in eastern Kentucky. It was felt by the committees, that by having this informa-

tion, members could make suggestions to communities involved that would be more intelligent and coordinated.

In addition to those present from the UMWA, State Department of Health, University of Kentucky Medical Center, and others, representatives of medical societies in counties having UMWA hospitals attended. Many things were discussed that those present felt would be helpful when passed on to people in the communities that are faced with losing the hospitals.

Postgraduate Medical Education Committee

Walter S. Coe, M.D., Chairman

Louisville **November 8, 1962**

The main item discussed at this Committee meeting was the future operation of the Postgraduate Medical Education Office since its annual income from KSMA had been reduced.

A lengthy session resulted in the appointment of a sub-committee that would determine if there were other sources of income available that could be used to maintain the PGME office in its present state.

The meeting closed with a discussion of the possibility of using educational television in postgraduate medical education.

KSMA Committee on AMA-ERF

Walter I. Hume, Jr., M.D., Chairman

Louisville **November 15, 1962**

The Committee held its first meeting and formulated its plans for the 1962-63 associational year. After reviewing the previous year's program, the Committee decided to plan this year's program on a continuous basis rather than to have a concerted single drive.

The Chairman stated that all contributions to AMA-ERF are tax deductible, and KSMA members should be reminded of this in order that they might make their contributions prior to December 31, 1962.

Mental Health Committee

Frank M. Gaines, Jr., M.D., Chairman

Louisville **November 29, 1962**

The reactivated Mental Health Committee held its first meeting and reviewed an 11-point program of Recommendations for State Action.

The AMA Congress on Mental Health was discussed, and the committee felt there was a need for stimulating an interest in mental health in physicians throughout the State.

It was reported to the committee that the Kentucky Department of Mental Health will receive a grant of which a portion will be used in developing a plan to concentrate on psychiatric treatment in the community rather than in the state hospitals.

Emergency Medical Services Committee

William T. Rumage, M.D., Chairman

Louisville **November 14, 1962**

After reviewing last year's program, the Committee decided on a number of plans for this year. A list of first aid supplies for fallout shelters will be sent to all county societies requesting their publicizing the availability of this list.

As a means of improving communication, the committee decided to find out how many county societies had a disaster planning or emergency medical services committee and the present chairman of the committee.

The Committee Chairman stated that the Medical Self-Help Training Program would be presented to all county societies that had requested it but had not received it.

The Committee announced its approval of a burn pack and an orthopedic pack being designed by the Flying Physicians Association. Each airplane in the organization will be equipped with one of these packs along with a supply of narcotics. It was also announced at the meeting that there would be a demonstration of the 200-bed emergency hospital in Bardstown, probably in December.

Senior Day Committee

Donald Chatham, M.D., Chairman

Louisville **November 28, 1962**

The Ninth Annual Senior Day will be held Monday, March 18, 1963, at the Medical Arts Building in Louisville, the Senior Day Committee decided at its meeting on November 28.

Senior Day is sponsored by KSMA in cooperation with the University of Louisville School of Medicine and the Jefferson County Medical Society. Individual members of the Jefferson County Society will be hosts to the members of the Senior Class.

The program will be similar to those in the past. However, because of the importance of the subject matter, the committee decided to add one additional presentation, "Legislation and Politics".

Doctor Moss, Bowling Green, Feted

Robert Carlisle Moss, M.D., 75, Bowling Green, was honored December 11 by members of the Warren, Butler and Edmonson County Medical Societies for 50 years of practice. Doctor Moss, a former state senator, is the son of a physician, Virgil Moss, M.D., who practiced at Rockfield for 60 years. The younger Doctor Moss practiced at Rockfield after graduation from the School of Medicine of the University of Louisville in 1912. He moved to Bowling Green in 1935 and is still active in the profession.

Lawrence U. Gilliam, M.D., has opened an office at Corbin, Ky., for the practice of pediatrics. He is associated with Keith P. Smith, M.D., and Frank Catron, M.D. Doctor Gilliam was in general practice at Corbin from 1950 to 1953 when he became a resident at Children's and General Hospital, Louisville. In 1957 he opened an office for the practice of pediatrics at Louisville which he continued until he returned to Corbin. He is a 1950 graduate of the University of Louisville School of Medicine.

William J. Cates, M.D., Cloverport, Ky., was elected to the Frederick Fraize Board of Education at the November 6 general election. Doctor Cates, a general practitioner, is a 1958 graduate of the Boston University School of Medicine.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

Submit Dates for P G Calendar

At this time of the year and in the next few weeks, many medical organizations are setting dates for their spring and summer meetings. At the same time they are choosing the topics to be discussed, arranging for speakers and planning programs.

The Postgraduate Medical Education office of the Kentucky State Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Coming Education Opportunities" calendar in The Journal. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KSMA Postgraduate Medical Education Office, 3532 Janet Avenue, Louisville 5, Ky.

Cardiology Course Reset

The postgraduate course in Cardiology, scheduled for presentation by the University of Kentucky Medical Center in January, has been canceled and rescheduled for May 9-11, 1963.

Tuition will be $15. Additional information may be obtained from Nicholas J. Pisacano, M.D., director, Continuing Medical Education, University of Kentucky Medical Center, Lexington.

In Kentucky

JANUARY

16 — "Electrocardiogram Interpretation," 7 to 9 p.m., Wednesday evenings, Louisville General Hospital, Louisville, Ky.

17 — Monthly University Surgical Day, University of Kentucky Medical Center, Lexington, Ky.

24 — KAGP Northern Kentucky Seminar, Sheraton Gibson Hotel, Cincinnati, Ohio.

25 — Pediatrics Department monthly program, 12:30 p.m., University of Kentucky Medical Center, Lexington, Ky.

FEBRUARY

8 — Kentucky Radiological Society, Sheraton Hotel, Louisville, Ky.

21 — Monthly University Surgical Day, University of Kentucky Medical Center, Lexington, Ky.

22 — Pediatrics Department monthly program, 12:30 p.m., University of Kentucky Medical Center, Lexington, Ky.

MARCH

18-19 — Southeastern Surgical Congress, Miami Beach, Fla.

27-28 — Symposium on Cardiovascular Diseases, Brown Hotel, Louisville, Ky.

MAY

9-11 — "Cardiology," University of Kentucky Medical Center, Lexington, Ky.

Surrounding States

JANUARY

28-Feb. 1 — Clinical III Diagnostic Use of Radio Isotopes, Oak Ridge Institute of Nuclear Studies, Medical Division, Oak Ridge, Tenn.

FEBRUARY

6-8 — American Academy of Occupational Medicine, Sheraton Lincoln Hotel, Indianapolis, Ind.

6-9 — American College of Radiology, Drake Hotel, Chicago, Ill.

10 — Seminar on Gastroenterology, University of Cincinnati College of Medicine, Cincinnati, Ohio.

13 — "Recent Developments in Diabetes Mellitus," Marion County General Hospital, Indianapolis, Ind.

21 — "Ophthalmology for the General Practitioner," Indiana University Medical Center, Indianapolis, Ind.

MARCH

28-30 — Fourth Oklahoma Colloquy on Advances in Medicine: Pulmonary Insufficiency, Oklahoma City, Okla.

APRIL

1-5 — 36th Annual Spring Congress in Ophthalmology and Otolaryngology, Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va.

NOVEMBER

18-21 — Meeting, Section of Ophthalmology and Otolaryngology of Southern Medical Association, New Orleans, La.

A five-day postgraduate course in the Medical Care of Adolescents will be given at Children's Hospital Medical Center, Boston, Mass., April 29-May 3, 1963.

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News Notes

Albert G. Lewis, Jr., M.D., is now on the staff of the State Tuberculosis Hospital District 6 at Glasgow, Ky. Doctor Lewis, an internist, is a 1945 graduate of Jefferson Medical College of Alabama. He interned at Grady Memorial Hospital and took his residency training at University of Alabama Hospitals at Birmingham. He also attended the University of Pennsylvania Graduate School of Medicine. Doctor Lewis served with the rank of captain in the USAF Air Rescue Service for two years. He was previously in practice at Birmingham, Ala., and Smithville, Mo., and has served as director of the Student Health Service at the University of Alabama and as director of Southwestern Tuberculosis Hospital, Tampa, Fla.

Ted D. Ballard, M.D., has entered general practice at Lexington. Doctor Ballard is a 1961 graduate of the University of Louisville and interned at the U. S. Public Health Service Hospital at San Francisco, Calif. He served as a major for four years with the USPHS.

Vernon H. Fitchett, M.D., has become associated with the Trover Clinic, Madisonville, Ky., for the practice of general surgery. Doctor Fitchett is a 1953 graduate of the University of Iowa School of Medicine and interned at the U. S. Naval Hospital, Bremerton, Washington. His residency training was accomplished at the Veterans Administration Hospital at Portland, Ore., and at the U. S. Naval Hospital at St. Albans, N. Y. He previously was assistant chief of neurosurgery at the Naval Hospital at St. Albans.

Francis B. Wells, M.D., has joined **Claude W. Trapp, Jr., M.D.,** Lexington, Ky., in the practice of ophthalmology. Doctor Wells was graduated from the University of Louisville School of Medicine in 1954 and interned at Kentucky Baptist Hospital, Louisville. His residency training was done at Henry Ford Hospital, Detroit, Mich. He was on the staff of the Henry Ford Hospital before returning to Kentucky.

The Kentucky Junior Chamber of Commerce has "adopted" Children's Hospital, Louisville, as a state project to both publicize the care of free patients throughout the State and to raise funds in each local Jaycee area to reimburse the Hospital for funds expended for that area's residents. **David Colvin, M.D.,** Radcliff, is community health chairman of the Jaycees.

C. Dwight Townes, M.D., professor of ophthalmology and chief of the Section on Ophthalmology at the University of Louisville School of Medicine, will be one of the guest speakers at the 36th annual spring congress in ophthalmology and otolaryngology of the Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va., April 1-5, 1963.

Clarence J. Mills, M.D., has opened an office for the general practice of medicine at Clinton, Ky. Doctor Mills was graduated from the University of Louisville School of Medicine in 1961 and interned at S.S. Mary and Elizabeth Hospital, Louisville.

County Society Reports

McCracken

H. L. McPheeters, M.D., Kentucky commissioner of mental health, was the featured speaker at the October 24 meeting of the McCracken County Medical Society.

During the business session of the meeting, a motion was made, seconded and passed that county dues be raised to $35. The committee for mass polio immunization, it was announced, had been dissolved because of adverse publicity received by Type III vaccine.

Walter Johnson, M.D., was named chairman, and W. P. Hall, M.D., and R. M. Wooldridge, M.D., members, of a nominating committee to make nominations for official vacancies occurring in December.

Shelby-Oldham-Henry

New officers of the Shelby-Oldham-Henry County Medical Society, who took office January 1, are, as follows: President, John L. Leland, M.D., Crestwood; president-elect, Robert W. Hamm, M.D., Shelbyville; secretary-treasurer, C. C. Risk, D.D.S., Shelbyville; delegate to KSMA, M. D. Klein, M.D., Shelbyville; alternate, Donald Chatham, M.D., Shelbyville.

In Memoriam

ROBERT GLADSTONE WEBB
Livingston
1879-1962

Robert Gladstone Webb, M.D., 83, Livingston, Ky., general practitioner at Livingston for 56 years, died November 23 at Rockcastle County Baptist Hospital, Mt. Vernon. Doctor Webb was graduated from the old Louisville Medical College in 1906 and began practicing at Livingston that same year. He was secretary of the Rockcastle County Medical Society.

Doctor Webb was honored when he completed 50 years of practice in 1956 by church, business and civic groups in Rockcastle County.

EDWARD KILGORE MARTIN, M.D.
Frankfort
1899-1962

Edward Kilgore Martin, Sr., M.D., 63, Frankfort, Ky., obstetrician and gynecologist, died December 1 at his home, following a long illness. Doctor Martin was a 1927 graduate of the Rush Medical College, Chicago, and started practice at Frankfort in 1932.

He was a founding fellow of the American College of Obstetricians and Gynecologists and a past president of the Franklin County Medical Society.

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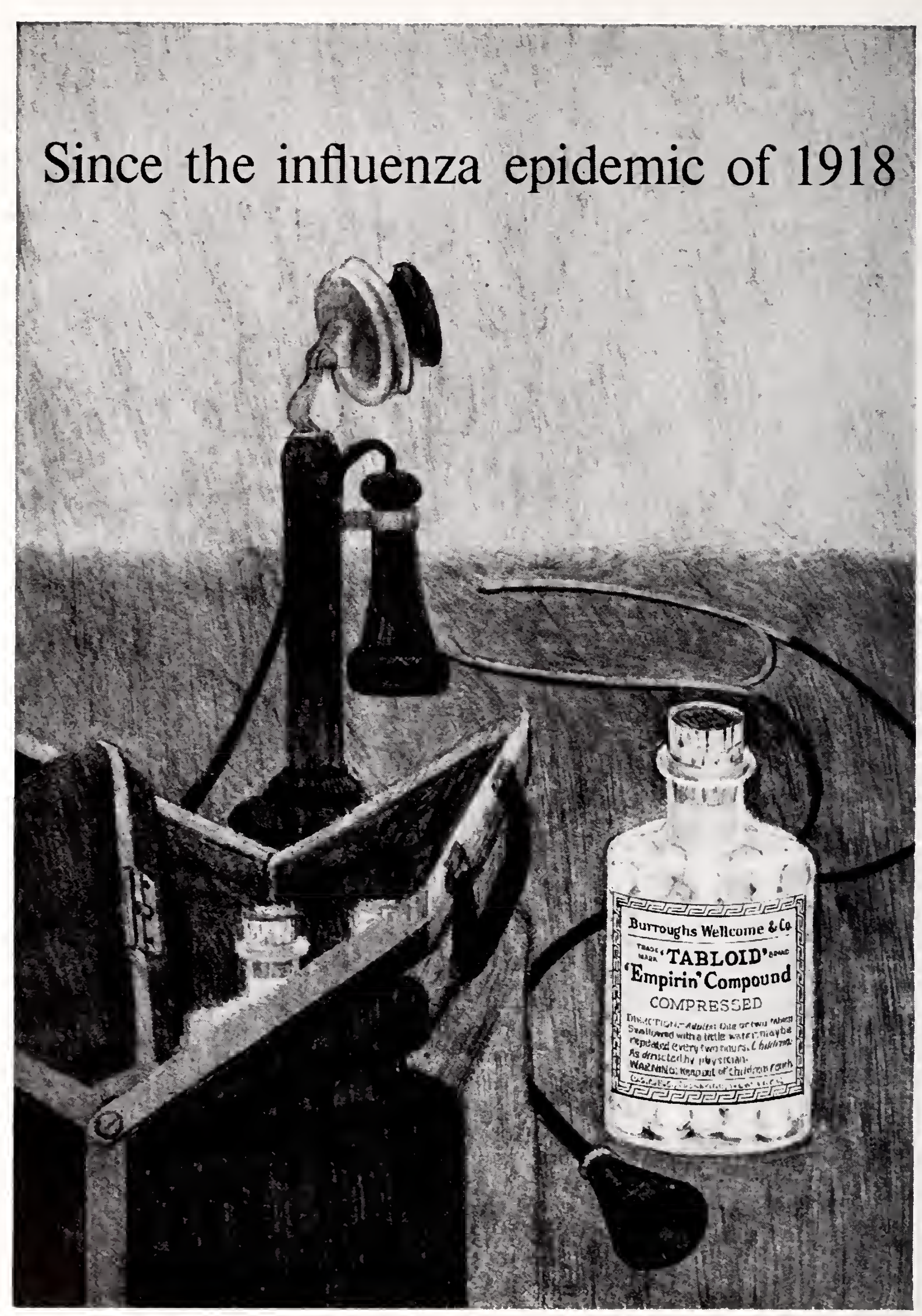
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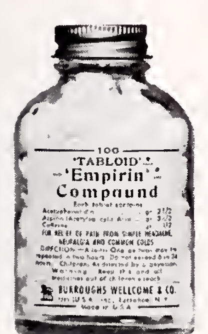

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*Levin, S. J.: **Pediat. Clin. North America 1:975, Nov., 1954.**

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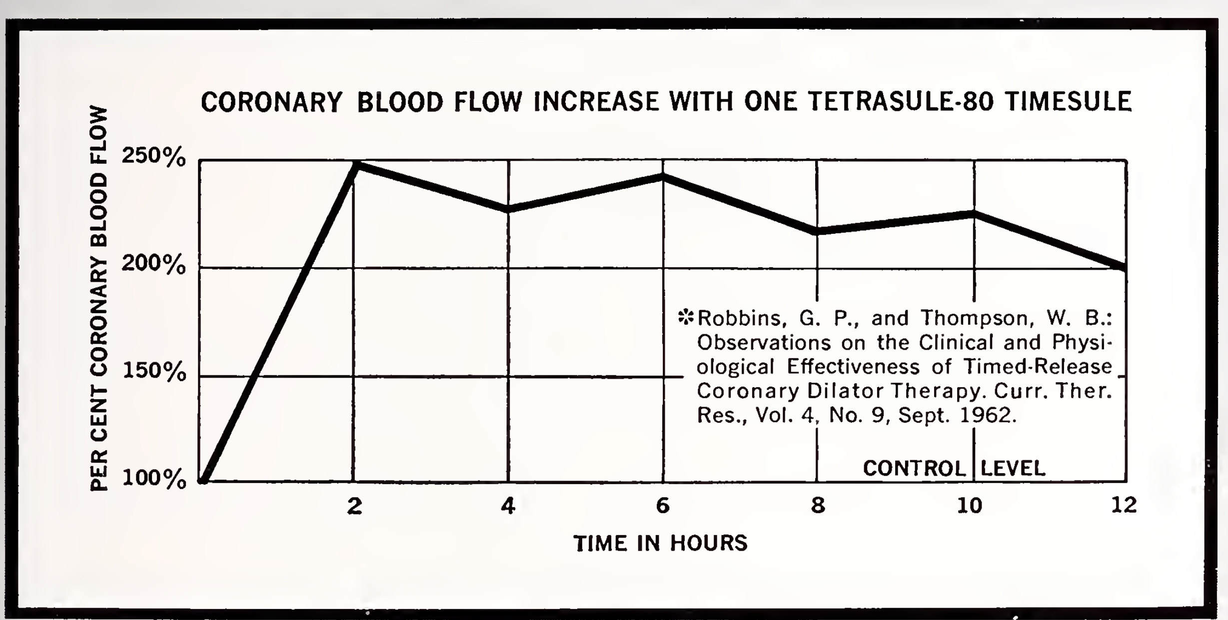

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IN THE BOOKS

DIAGNOSIS AND MANAGEMENT OF PAIN SYNDROMES: by Bernard E. Finneson, M.D.; published by W. B. Saunders Co., Philadelphia; pages, 261; price, $8.50.

This monograph is an attempt to provide a practical and useful guide to the management of the pain problem commonly encountered in practice. Most of the techniques described are widely accepted and no claim is made for original methods or for a new concept. The material is based on the author's personal experience in managing pain problems and the profuse procedures are those that he has found to be most useful.

The author states that he has purposely limited the scope of the book to the technique that worked best for him and he has endeavored to impart in an orderly and logical approach the management of a given pain problem. While a number of the techniques described are solely within the discipline of neurosurgery, they are not intended as an inducement to those not trained in this field to "try their hand" at an unfamiliar procedure: However, an appreciation of the available operative procedures is helpful to anyone who is involved in the management of pain in order to indicate what can and what cannot be accomplished.

The book is divided into 11 chapters with a brief but complete description of the mechanisms and pathways of pain and its effects. The principles of treatment are discussed and I might add there are very excellent illustrations to outline the various procedures described. These illustrations are by Barbara R. Finneson, the author's wife. The typography and selection of type for this book makes it an easy book to read. The chapters continue with a full description of various pains from headache, facial pain and pain involving the various segments of the body. Included is a section on the reflex dystrophies and intractable pain and cancer.

The author has done a creditable job of organizing his material and I can recommend this as an excellent reference source for any physician who deals with patients that complain of pain.

Blaine Lewis, M.D.

PRIMER OF CLINICAL MEASUREMENT OF BLOOD PRESSURE; by George E. Burch, M.D., and Nicholas P. DePasquale, M.D.; published by The C. V. Mosby Company, St. Louis, Mo.; pages 141; price, $5.50.

In the introduction to this book, the author states: "This Monograph, primarily concerned with the technique of recording arterial blood pressure in patients, is intended for undergraduate and postgraduate students of medicine and for physicians who may not have considered many of the practical principles and problems of accurate blood pressure recording." They have partially succeeded in attaining this goal.

A chronological history of blood pressure recording devices is presented as a background. This is developed further with diagrams of the instruments and discussions of their mechanical behavior. The presentation, however, tends to be cumbersome and unnecessary for the authors' expressed purpose.

Sources of error in the determination of the blood pressure are discussed in an excellent manner. Remarks concerning the physiology of the arterial blood pressure are quite inadequately discussed, except for the description of Korotkoff's sound which is effectively handled. However, a selective bibliography is appended for those who wish to investigate selected problems in detail.

Normal values of arterial blood pressure are presented. They are summarized from various reports in the literature. The final chapter is devoted to the diagnostic applications of blood pressure measurements. Since only 11 pages are devoted to this important subject, the remarks are very cursory.

In their closing remarks the authors state: "If proper habits, proper equipment and proper techniques are used routinely in recording the blood pressure, it will then be found that it is just as easy to record blood pressure accurately and reliably as it is to record it haphazardly and erroneously."

Since, in our experience in this area, these remarks apply to medical students, it is to them that this book is recommended.

Morris M. Weiss, Sr., M.D.
Morris M. Weiss, Jr., M.D.

WOUND BALLISTICS: edited by Colonel James B. Coates, Jr., MC, and Major James C. Beyer, MC, Medical Department, U.S. Army, Office of the Surgeon General, Department of the Army; published by Superintendent of Documents, U.S. Government Printing Office, Washington, D.C.; pages 883; price, $7.50.

This book is chiefly of interest to men who design weapons and protective devices and to medical officers who are primarily interested in promulgating policy of care of the wounded.

It contains a great deal of authoritative information concerning the relationship of weapon characteristics, various protective devices and the resulting wounds.

There are detailed technical analyses of the performance characteristics of enemy and American weapons, varying from pistols to heavy artillery. The influence of design of body armor on wounds is also explained.

Two major battles are described in detail, that of Cassino, Italy, and of Bougainville in the Pacific. The effects of terrain, weather, enemy strength, weapons used, allied strength and the problems of medical supply and evacuation are related to the number, types of wounds, morbidity and mortality.

One chapter deals with the mechanism of wound-

ing. First there is a detailed description of the various instruments, such as high-speed cameras, x-ray machines and of the design of the experiments. In it there is a description of what happens when a missile hits gelatin blocks, water and anesthetized experimental animals. From this data is deduced the effects on human tissue.

This book is a well-organized, well-written, authoritative treatise and should be of great interest to those concerned with the subject matter that it contains.

James C. Drye, M.D.

"**Physicians very often have differing opinions about the** usefulness of an agent in treating a particular disease. Many eminent physicians, for example, favor the use of corticosteroids in the treatment of rheumatoid arthritis, but others believe that the corticosteroids are not the drug of choice for this purpose. Under such circumstances, it is difficult, if not impossible, to determine the exact effectiveness of the corticosteroids in treating rheumatoid arthritis. It would be an appalling development to have the Food and Drug Administration, directly or indirectly, limiting the rights and responsibilities of a prescribing physician by determining, for example, the corticosteroids should not be marketed because of the FDA's opinion that they lack efficacy."—I. S. Ravdin, M.D., professor of surgery, University of Pennsylvania School of Medicine, to House Interstate and Foreign Commerce Committee.

"**It is of fundamental importance that new drugs, before** being used widely in research and being marketed, should be adequately tested for safety. Of equal importance is the fact that there should be a continuous flow of new and improved drugs. Any legislation on this subject, therefore, needs to strike a fine balance. On the one hand, it properly seeks to broaden and strengthen controls over drugs both new and old, to protect the public interest. On the other hand, it must encourage rather than obstruct the continuing flow in the number and kind of new drugs that are needed for better health."—Leonard A. Scheele, M.D., senior vice president, Warner-Lambert Pharmaceutical Company, to House Interstate and Foreign Commerce Committee.

"We find many references to 'human guinea pigs', surely one of the most frightening and degrading terms ever invented. Generally, the term refers to the first use, in the hands of a highly competent doctor, of a compound which had been studied extensively in animals and which had shown promise of being useful as an agent in humans. This should be noted: The physician himself—acting with complete independence —decides whether he will participate in the evaluation of a new compound. And then he makes his own professional judgments as to its usefulness and effectiveness. In other words, while clinical trials are necessary to industry, they are not a process controlled by industry."—John T. Connor, president, Merck & Co., to American Hospital Association, September 18, 1962.

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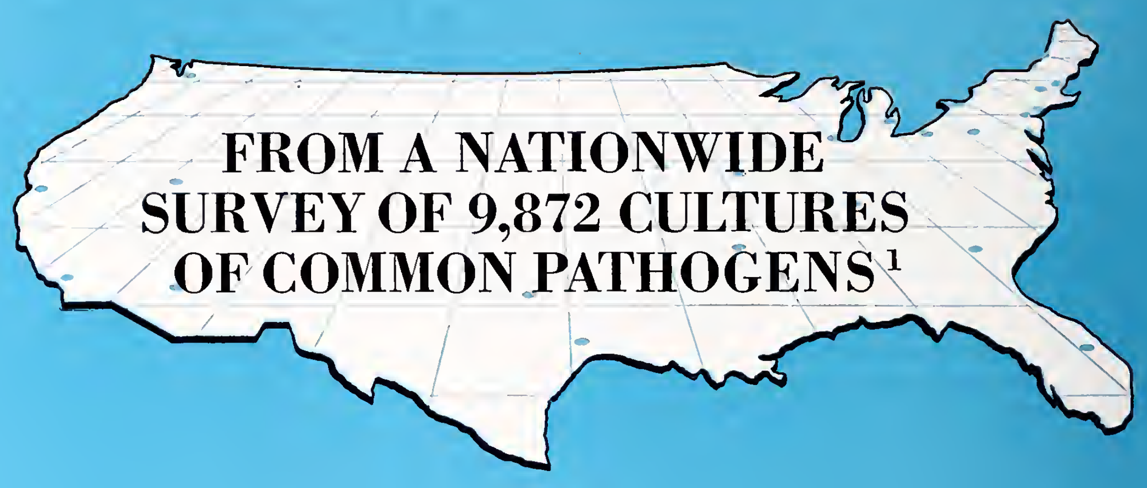
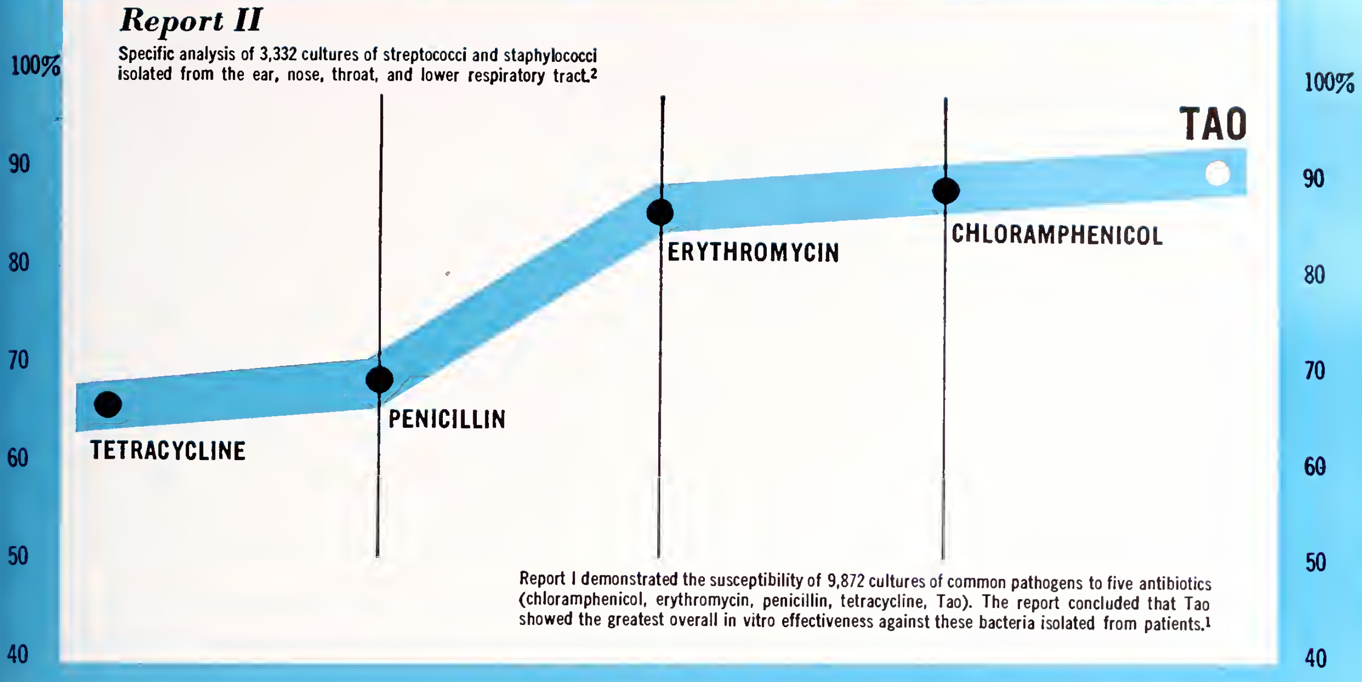


Conclusions of Nationwide Survey: *Report I*

1. **Even after five years of general use, Tao, of the antibiotics tested, demonstrated greatest activity against respiratory streptococci and staphylococci (3,332 cultures).**

2. **Overall results showed a higher percentage of susceptibility among these common pathogens to Tao than to the other antibiotics.** Susceptibility to Tao was greatest, not only in respiratory streptococci and staphylococci, but also in these organisms isolated from skin and soft tissue (3,423 cultures), genitourinary and gastrointestinal tracts and other sources (2,458 cultures). Susceptibility was equal to all antibiotics tested in pneumococci from unspecified sources (463 cultures), and less to Tao in H. influenzae from unspecified sources (196 cultures).

3. **Tao has been used for five years without development of predictable cross resistance.** In 1958 and 1961, approximately 73% and 70%, respectively, of erythromycin-resistant problem staphylococci showed susceptibility to Tao.[3,4] The present study confirms the continuing high degree of Tao activity even against these pathogens. Of 1,592 cultures of erythromycin-resistant staphylococci, 68% were susceptible to Tao, while in the reverse situation, only 33% of 768 Tao-resistant staphylococci were susceptible to erythromycin.



Report II

Results of Bacterial Susceptibility in 3,332 Respiratory Pathogens

References

1. "Bacterial Susceptibility Patterns: A Geographic Survey." Fowler, J. Ralph, M.D., and Watters, John L., M.D. Scientific Exhibit presented at the Annual Meeting of the American Society of Clinical Pathologists, Chicago, Ill., August 31 to September 9, 1962. 2. Fowler, J. Ralph, Watters, John L. and Levy, Arthur M.: Bacterial Susceptibility Patterns as Related to Geographic Variation and Anatomical Source. In press. 3. English, A. R., and Fink, F. C.: Antibiot. & Chemother. 8:420 (Aug.) 1958. 4. English, A. R., and Fink, F. C.: Antibiot. and Chemother. 11:648 (Oct.) 1961.

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WASHINGTON NEWS DIGEST

WASHINGTON, D. C.—Health, Education and Welfare Secretary Anthony J. Celebrezze expressed the belief that state and local governments have the primary responsibility for welfare programs and other public services.

He told a National Press Club luncheon:

"The federal government's responsibility should be limited to those matters which are of primary national interest and cannot be effectively carried on through individual or local community effort."

He also said that his basic welfare program policy would be to "help people help themselves."

But Secretary Celebrezze does not follow this philosophy of government to the point of weakening his support of the Kennedy Administration's Social Security hospitalization legislation. The Administration has said that it will push again for passage of such legislation in the new Congress convening January 9. But Mr. Celebrezze conceded it would be difficult to secure House approval.

The Administration gave no indication in pre-session talk whether the big push for legislation would be made this year or in 1964.

The House of Delegates of the American Medical Association, at its recent 16th Clinical Meeting in Los Angeles, reaffirmed its opposition to the Social Security approach in providing health care for the aged. The AMA also reaffirmed its support of the Kerr-Mills program.

George M. Fister, M.D., AMA president, said the AMA "will not compromise on the fundamental principles" in the controversy. Noting that the medical profession again faces a hard fight on the issue in Congress, Doctor Fister expressed confidence that "we can again win."

A spokesman for the drug industry warned at a Washington, D.C., meeting of government and industry officials and consumers that enactment of the Administration medical care plan would open the way for the federal government "to extend its controls in all health areas, including drugs, ostensibly to assist patients economically to obtain these services."

The spokesman, Francis C. Brown, president of Schering Corporation, added: "Those who say it can't happen here may be deluding themselves. It can and it will if we permit it."

The new Congress has only four physician members as compared to seven in the 1961-62 session.

Reelected senator was Ernest Gruening, M.D., (D., Alaska) and reelected representatives were Durward Hall, M.D., (R., Mo.) and Thomas Morgan, M.D., (D., Pa.). James D. Weaver, M.D., (R., Pa.) captured a House seat in his first political race.

Walter Judd, M.D., Republican representative of Minnesota, and Ivor Fenton, M.D., Republican representative of Pennsylvania, were defeated in contests where redistricting was a major factor.

Dale Alford, M.D., Democratic representative of Arkansas, gave up his House seat and ran unsuccessfully for governor of Arkansas. Edwin Durno, M.D., Republican representative of Oregon, lost in a bid to switch from the House to the Senate.

The overall election results added four Democrats in the Senate but appointment of a Republican to succeed a deceased Democrat cut the net gain to three. The Republicans increased their House strength by two members.

* * * * * *

The American Hospital Association and the Defense Department agreed on a program to use hospitals as public fallout shelters in event of nuclear attack.

In a joint statement, the AHA and the Defense Department said that "in these times every hospital has the responsibility to take practical and sensible measures to minimize loss of life resulting from radioactive fallout" should there be a nuclear attack.

It was estimated about 6,200 U. S. hospitals presently could provide fallout protection for more than 3,000,000 persons.

The program calls for the Defense Department to provide the cooperating hospitals with emergency supplies of medical material, food and other emergency items to be stockpiled in basements and other places judged "safe" from fallout.

If Congress approves the Administration's request for a national shelter program, federal funds will be available to hospitals for additional construction that would be suitable for operating rooms, storage space, automobile parking and other similar purposes when not needed for fallout shelters.

* * * * * *

American consumers spent a new high of $21,100,-000,000 for health care in 1961, according to the Social Security Administration.

The federal agency reported that the total private outlay for health care, which include $14,400,000,000 in direct out-of-pocket expenditures and $6,700,000,000 paid for health insurance, exceeded by $1,300,000,000 the total spent in 1960.

The 1961 consumer expenditure for health care amounted to $116.60 for each American. Direct expenditures per capita were $79.76 and payments for health insurance amounted to $36.84 per capita.

These sums applied only to private expenditures for health care provided through private organizations to the needy.

A breakdown by category of expenditures showed

how the consumer's health care dollar in 1961 was divided—hospital care, 27.6 cents; physicians' services, 27.6 cents; drugs, 19 cents; dental care, 9.8 cents; eyeglasses and appliances, 6 cents; nursing and other professional care, 4 cents; nursing-home care, 1.4 cents. The remaining 4.6 cents represented the net cost of health insurance.

Of the total $6,700,000,000 expenditure for health insurance premiums, 45.4% was paid to Blue Cross-Blue Shield plans; 38.1% to insurance companies for group coverage; 9.4% to insurance companies for individual policies, and 7.1% to independent health insurance plans.

It was estimated that insurance benefits paid 28.3% of the consumer's total 1961 health care bill, exclusive of the cost of insurance. Insurance met 66% of all charges for hospital care; 30% of all charges for physicians' services, and 1.5% of the cost of all other items, including dental care, nursing service, drugs and nursing-home care.

Kerr-Mills

(Continued from page 53)

present budgetary limits, eliminates the forseeable possibility of any liberalizations or additions to benefits given under the program with the exception of nursing home care.

Thus, our efforts at the present are confined to administering the benefits of the program as they now stand and planning improvements in the administrative details. Administrative costs, by the way, have now decreased to about 10 cents per $1. We are considering several improvements in this aspect of the program which may reduce costs even further and which will simplify the administrative procedures of the program. Any future steps we may take, as far as we can see at the moment, will lie in that direction.

"The drug industry spends more than $100,000,000 annually for research, and no other industry in this country spends that much. It must be emphasized that for every thousand products researched by the drug industry only 40 or 50 reach a marketable stage. Because I am a physician who started practicing medicine before the days of the wonder drugs, I know their real value. As doctors, we have an understanding of the worth of these drugs. We can do so much more with these drugs today than we could with the drugs available to us 15 years ago. All of this means progress. Of course, it also means greater costs,"—Edward R. Annis, M.D., in *Pennsylvania Medical Journal*, October 1962.

Smith, Kline & French Laboratories, Philadelphia, recently noted the delivery of a total of 5,000 speeches made by representatives of the firm in its efforts "to carry to the grass roots the story of the prescription drug industry's contributions to the health team." Speakers from the firm have made 34 talks in Kentucky to a total audience of more than 1,200 persons.

Lloyd M. Hall, M.D., Salyersville, was elected mayor of that city in the November 6 general election. Doctor Hall is a 1932 graduate of the University of Louisville School of Medicine.

Frederick A. Cline, M.D., Fort Thomas, Ky., pediatrician, was elected first chairman of the new Northern Kentucky Health Council. At the first meeting of the group, Strawn Taylor, director of records and statistics for the Kentucky State Health Department, said the Council was the first of its kind formed in Kentucky through active citizen participation.

W. A. Weldon, M.D., Glasgow, Ky., was the first recipient of the new "Businessman-Farmer Award" presented at the Farm-City Week banquet at Glasgow November 16. The award is presented to the City-County businessman-farmer who has provided more influence to mold the interests of the city and county in a mutual agreement than any other person in Barren County.

B. G. Jackson, M.D., is now in general practice at Princeton, Ky., in association with **N. H. Talley, M.D.** Doctor Jackson was graduated from the University of Louisville School of Medicine in 1959. He interned at St. Louis County Hospital and has served one year of residency in surgery at that hospital.

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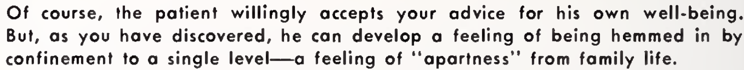

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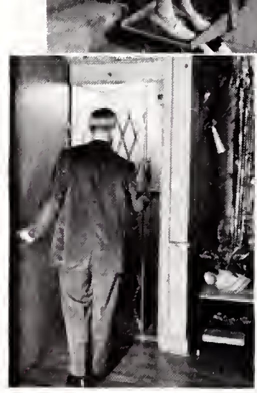

New KSMA Members Reported

The following—all of Lexington—have become members of the Kentucky State Medical Association:

W. K. Burkhart, M.D.

T. D. Ballard, M.D.

L. R. Bryant, M.D.

R. H. Fine, M.D.

J. E. Myers, M.D.

J. A. Orr, M.D.

F. Norman Vickers, M.D.

"Today tuberculosis, pneumonia and other scourges of the recent past are no longer among the top 10 killers, due largely to breakthrough in drug therapy. But we are still confronted with the scourge of diseases such as heart disease, cancer, mental illness, neurological disorders and many others. I am sure no one of us would wish to retard much-needed research leading to new drugs or in any way to delay the availability of existing drugs for cancer and other uncured ailments. Keeping a useful drug off the market or unduly delaying its marketing may frequently in itself be a great detriment to public health. Today we regard the drugs of 1942 as outmoded. It is to be hoped that the doctors of 1982 will consider the drugs of 1962 just as outmoded. That can be accomplished only by continuation of the present dynamic drug research program."—Chester S. Keefer, M.D., director, Boston University-Massachusetts Memorial Hospitals Center, to House Interstate and Foreign Commerce Committee.

"It has been the experience of my company that the cost of development of a new drug for marketing is approximately $5,000,000. I might add that the cost of other major pharmaceutical houses is about the same as ours. If it is made more difficult and more costly to bring new drugs to market because of added red tape and restrictions—if a new drug can be barred because of conflicting views, honestly held but involving subjective judgments on its effectiveness—research is seriously threatened and indeed may be effectively foreclosed in the case of drugs for serious diseases which are not highly prevalent. It is vitally important that development of new products of potential public significance not be shut off for such reasons, for the result will be to hamper seriously progress in the conquest of disease and the prolongation of life."—Theodore G. Klumpp, M.D., president, Winthrop Laboratories, to House Interstate and Foreign Commerce Committee, August 20, 1962.

"Despite the seeming inefficiencies of free competion, I, as a physician, would rather be deluged with more medical preparations than be forced to sit idle at the bedside of a patient—doing nothing because there are not enough drugs to save lives or comfort my patients. As the president of a pharmaceutical firm, I would rather be accused of trying too hard to market my useful products than to default on marketing and—as a result—lose sales and thereby increase the costs of products to the consumer."—Theodore Klumpp, M.D., *New Medical Material.*

News Notes

W. Burr Atkinson, M.D., Campbellsville, recently was commissioned Admiral in the Taylor County Navy by the Campbellsville News Journal for his "unselfish civic service to his fellow citizens."

The 1963 American Industrial Health Conference will be held March 18-21 in Washington, D.C. The conference comprises the annual meetings of the Industrial Medical Association and the American Association of Industrial Nurses. Further information may be obtained from the American Industrial Health Conference, 55 E. Washington St., Chicago 2, Illinois.

The American College of Allergists' graduate instructional course and 19th annual congress will be held March 24-29, 1963, at Americana of New York, New York City. For further information write to: John D. Gillaspie, M.D, 2141 14th St., Boulder, Colorado.

The alarming number of infants and small children who have died as a result of the misuse of thin plastic flim from cleaning or laundry bags and bags used to package many new items has been pointed out by the Division of Public Health Education of the Kentucky State Department of Health. In the last three months—in Kentucky five infants under six months of age have died as a result of the misuse of the film. The public is urged by the Department to destroy all plastic bags and never substitute them for bed clothing or playthings.

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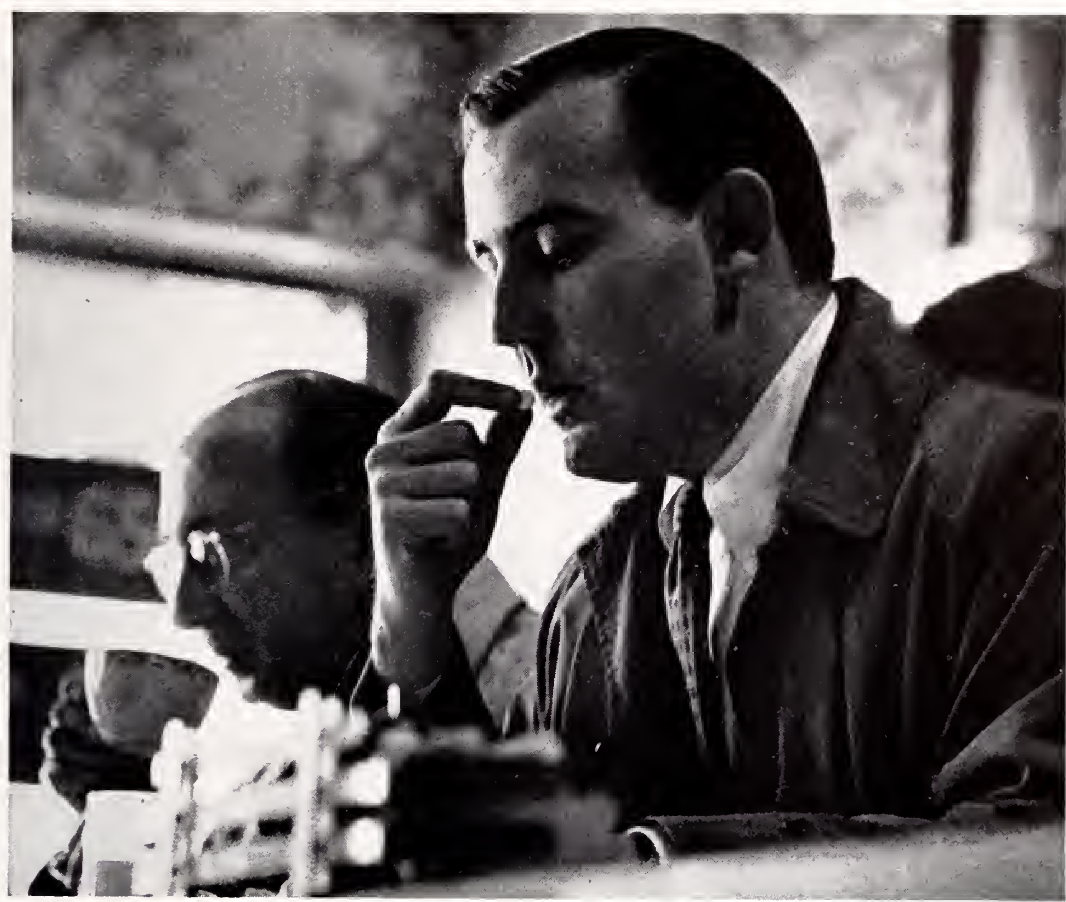

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*Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961.

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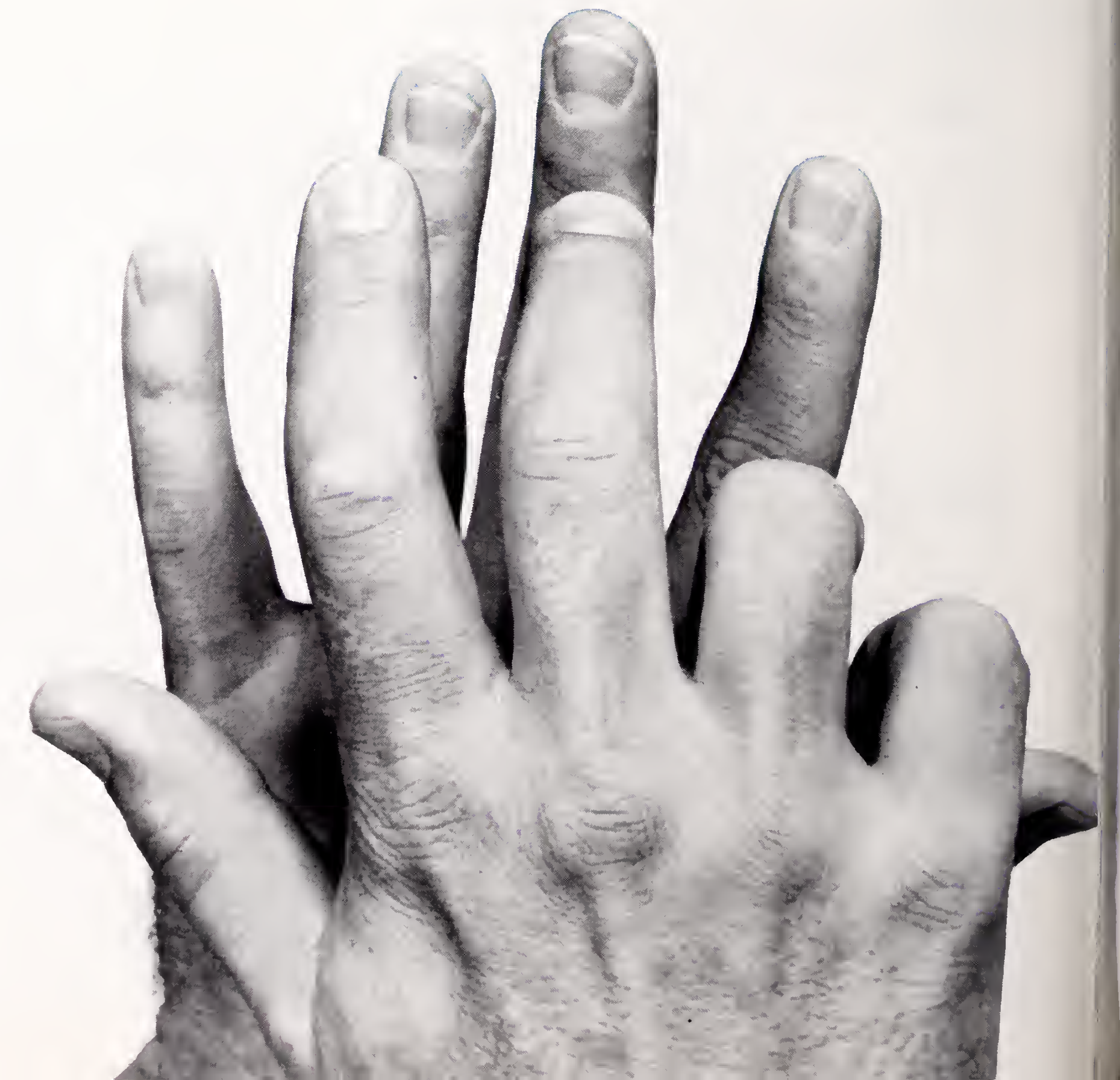

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References: (1) Thacher, H. C., & Fishman, L.: *J. Maine M. A.* **52**:84, 1961. (2) Hopkins, E. W.: *Postgrad. Med.* **29**:451, 1961. (3) Hall, W. H.: *M. Clin. North America* **43**:191, 1959. (4) Krugman, S.: *Pediat. Clin. North America* **8**:1199, 1961. (5) Ede, S.; Davis, G. M., & Holmes, F. H.: *J.A.M.A.* **170**:638, 1959. (6) Wolfsohn, A. W.: *Connecticut Med.* **22**:769, 1958. (7) Calvy, G. L.: *New England J. Med.* **259**:532, 1958. (8) Hendren, W. H., III, & Haggerty, R. J.: *J.A.M.A.* **168**:6, 1958. (9) Cutts, M.: *Rhode Island M. J.* **43**:388, 1960. (10) Berman, W. E., & Holtzman, A. E.: *California Med.* **92**:339, 1960. (11) Vetto, R. R.: *J.A.M.A.* **173**:990, 1960. (12) Sia, C. C. J., & Brainard, S. C.: *Hawaii M. J.* **17**:339, 1958. (13) Rosenthal, I. M.: *GP* **17**:77 (March) 1958. (14) Gaisford, W.: *Brit. M. J.* **1**:230, 1959.

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MESSAGE FROM THE PRESIDENT

Physicians Must Police Their Own Ranks

MOST MEN, who decide to become doctors, have known a doctor who stood out as a leader, a kind considerate person who listened to their questions, or a friend who was called when they were ill. Some single or multiple experience has set up the doctor as a model that the young man would like to copy. That type of doctor is the image the public wants, and most of us would like to be a part of that image.

Good health is valued above material possessions. Citizens of the United States depend on us to guard and protect their health to the best of our ability. We have a duty not to betray that trust.

The committees on admissions of our medical schools use every human precaution to select men who will be good doctors and good citizens. However, one out of every 100 graduates is so weak that he yields to the pressures of life and becomes an addict or an alcoholic. There are others who fall victim to other temptations. The percentage who do not stand the test of being honest and honorable citizens is no greater than in other professions or types of endeavor. But we are dealing with human life and more is expected of us.

Recently the press broadcast the opinions that there are some cheaters among us and, if we don't clean our house, someone else will do it for us. In June 1961 the AMA House of Delegates passed a resolution to discipline our erring members. The officers of your State Medical Society have given much thought and time to this problem. Physicians must police their own ranks more carefully and remove rather than protect the incompetent and dishonest practitioners.

In the last 30 years there has been a continual decrease in the number of doctors in private practice and an increase in the teaching, research and government employees. All are needed and each individual physician has to decide which type of endeavor he prefers. We have 2,705 doctors in Kentucky; 2,148 of these are members of our State Society. We need every M.D. in the State to be an active member of our organization. Your cooperation is earnestly solicited so that the citizens of our State can have the best possible Medical Care.

David M. Cox

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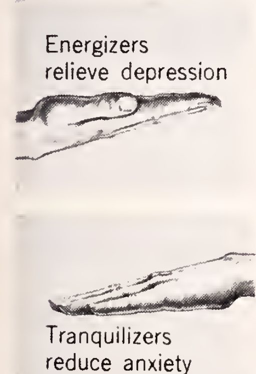

Deprol both lifts depression <u>and</u> calms anxiety

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Whether treating tsutsugamushi or a host of other infections, physicians throughout the world continue to rely on TERRAMYCIN for its outstanding safety, effectiveness and excellent tolerability. Not a single case of phototoxic reaction, blood dyscrasia or neurologic disturbance directly attributable to TERRAMYCIN has been reported in more than 3,000 clinical papers in the last 12 years. *In your practice, the next infection you see will very likely be "Terra-responsive."*

Tsutsugamushi, or scrub typhus, was responsible for incapacitating nearly 7,000 American soldiers during World War II. This disease is prevalent in areas overrun by jungle rats infested with mites carrying *Rickettsia tsutsugamushi.* Symptoms include a primary lesion at the site of the mite-bite, fever reaching as high as 105°, and a cutaneous rash. Injected conjunctivae, deafness, delirium and racking cough mark the advance of the disease. Mortality rates as high as 60 per cent have been reported. Terramycin is one of the antibiotics of choice for rapid and effective control of the acute stage of the infection. Patients become afebrile and virtually asymptomatic 24 to 36 hours after beginning treatment.

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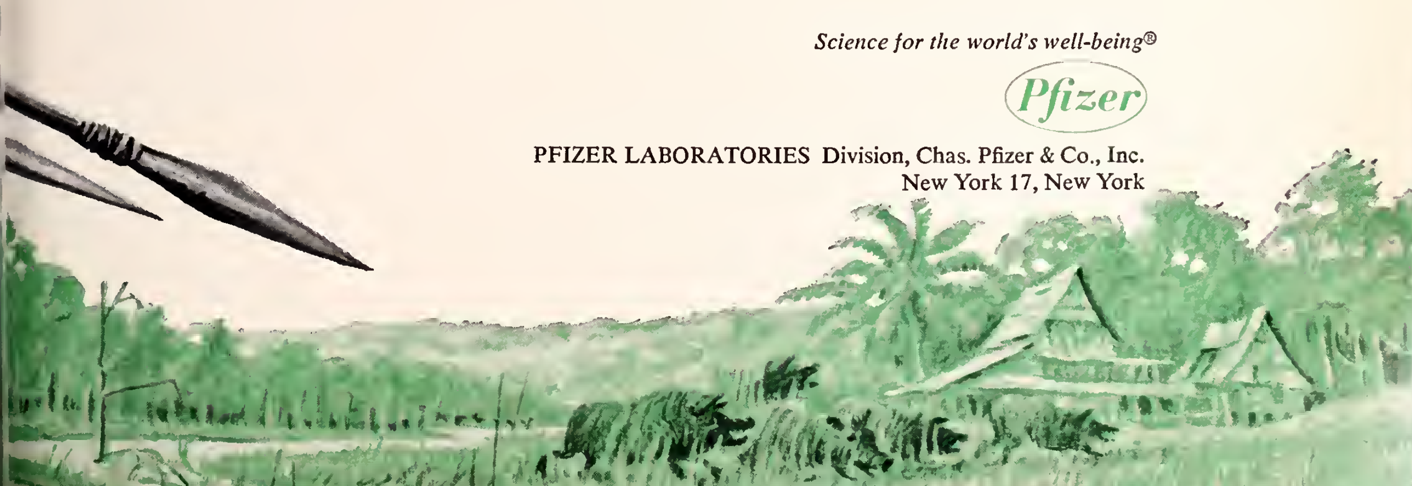

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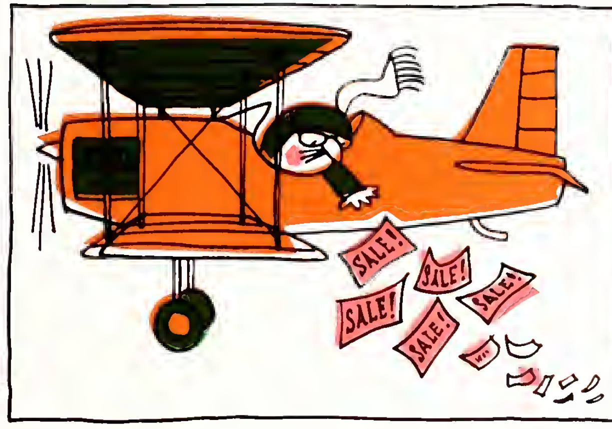

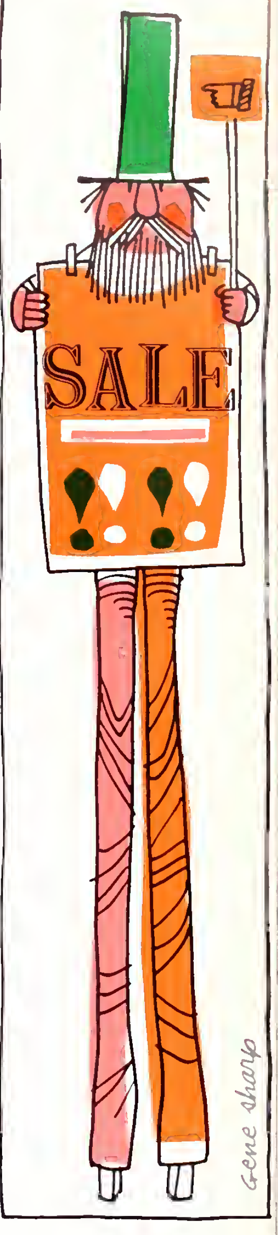

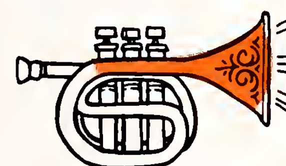

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THE INSURANCE PAGE

A Quarter Century of Progress

WITH THE advent of 1963, America's Blue Shield program has become a quarter-century old. For it was in 1938 that the first Blue Shield Plans were inaugurated in California and Michigan. In the light of today's mercurial pace of socio-economic evolution, 25 years is a long, long time.

Age Brings Advantages

Age has brought certain advantages to Blue Shield. There is the security that comes with the accretion of a vast enrollment and substantial assets. There is the confidence born of successful administration and solid actuarial experience.

But maturity also brings problems. The very size of Blue Shield tends to deprive it of the flexibility that has enabled it to respond promptly to new challenges in the past. Size makes for inertia, for complaisancy and overconfidence—which could be fatal in a political environment replete with booby traps for fat cats.

The problems confronting Blue Shield—medicine's response to the national demand for medical prepayment—are as big and complex today as Blue Shield itself is big and complex. We must find some way to control the persistent inflation of voluntary prepayment costs. We must somehow satisfy the popular demand for comprehensive medical prepayment without pricing ourselves out of the voluntary market. We must extend Blue Shield protection to the catastrophic long term illness without depriving our patients of that vitally important coverage for the early visit which has been a Blue Shield hallmark.

Get Message to New Physicians

Perhaps most important and basic of all: We must somehow get the Blue Shield message across to the several new generations of physicians who have come of age since Blue Shield was born. Many of these younger colleagues know little if anything of the crucial role played by our profession in creating and nurturing Blue Shield. Many of them do not realize why it is so vitally necessary for every practicing physician to identify himself with and to support Blue Shield, as the one and only prepayment plan guided by the medical profession and dedicated to the dominant American pattern of private practice.

Blue Shield's problems—and her opportunities and challenges—have grown right along with her enrollment. They are medicine's problems, and their solutions will call for the most devoted and imaginative leadership of which our profession is capable.

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Each tablet (or capsule) contains 16 mg. phenobarbital blended with 65 mg. Bensulfoid®. The Bensulfoid is an inert diluent present to permit slow absorption of the phenobarbital. The usual dosage is one tablet or capsule after meals and at bedtime. Solfoton is especially adapted to prolonged use because of its virtual freedom from depression and other side effects. Contra-indications: identical to those of ¼ gr. phenobarbital.

Poythress, White Section, Page 808 (1963 edition) and Product Identification Section

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WASHINGTON NEWS DIGEST

WASHINGTON, D. C.—The federal government appreciably increased its controls over the clinical testing of new drugs, including antibiotics, with new regulations effective February 7.

The new regulations of the Food and Drug Administration require that the FDA be put on notice and given full details about the distribution of drugs for investigational use; that clinical investigations be based on adequate studies on animals, and that the clinical tests be properly planned and executed by qualified investigators, and that the investigators and the FDA be kept fully informed of the adverse findings of other investigators during the progress of the investigations.

If an investigation develops evidence that the drug is not safe or is ineffective, the FDA said it will order discontinuance of clinical tests.

The old regulations did not require either an initial notice to FDA of a clinical trial of a new drug or subsequent reports on such use.

Before they were announced in their final form, numerous modifications were made in the version published on August 10, 1962, as proposed regulations. More than 300 written comments on the proposed regulations were received by the FDA. In addition, FDA officials met with representatives of the American Medical Association and various other interested scientific groups.

But the FDA did not make all the changes urged by the scientific groups.

The Pharmaceutical Manufacturers Association credited the Department of Health, Education and Welfare and the FDA with modifying the regulations as originally proposed sufficiently that "most of the major difficulties found by reputable medical scientists" had been resolved.

But the PMA said "the burden of paperwork imposed by the new regulations is enormous."

"The success of the Department meeting its stated goals will of course depend in large part on the wisdom of administration of these regulations," the PMA said. "It is hoped that remaining troublesome problems may be resolved in the near future by appropriate amendments."

One modification was designed to permit some flexibility in the planning of the investigation of the safety and effectiveness of a new drug. Another modification cut down on the record-keeping requirements.

To meet criticisms that the regulations as originally proposed would impinge upon the physician-patient relationship by calling for inspection of the clinical records, the FDA said:

"The provisions for inspection of the patient's records have been modified to make it clear that the investigator may withhold the names of volunteers or patients unless the records of a particular volunteer or patient require a more detailed study of drug effects, or unless there is reason to believe that the records do not represent actual results obtained.

". . . if the record has been sent to the sponsor by the investigator, there is no confidentiality, and the record is to be made available by the sponsor for inspection by a properly authorized employee of the Department of Health, Education and Welfare. Where the record has not been sent to the sponsor, the investigator is required to maintain it and make it available upon request of a scientifically trained and specially authorized employee of the Department."

The proposed regulations dealing with publication of findings of investigators were construed by some as restricting free flow of scientific information. But the FDA said the regulations were "not intended to bar factual news reporting to scientists or the public."

The proposed regulations also were said to deny extremely important new drugs, not yet approved for general distribution, to patients who might need them urgently as a life-saving measure. The FDA denied this, saying, "there is no bar in the regulations to giving the necessary instructions to and obtaining the necessary commitments from a new investigator by telephone in case this is needed to save a life."

Pending further consideration, radioactive new drugs were exempted from the new regulations if they are shipped in accordance with current regulations of the Atomic Energy Commission.

*** ***

The Public Health Service recommended use of Type III Sabin oral polio vaccine after having banned it for three months while its safety was being reviewed. But the PHS still recommended that older adults take it only if their risk of catching the disease is higher than normal.

Surgeon General Luther L. Terry acted upon the recommendation of his special polio advisory committee. Doctor Terry urged that communities use all three types of the Sabin vaccine in polio immunization campaigns with particular emphasis on children and young adults.

The advisory committee said:

"Because the need for immunization diminishes with advancing age and because potential risks of vaccine are believed by some to exist in adults, especially above the age of 30, vaccination should be used for adults only with the full recognition of its very small risks."

The PHS reported that polio continued to decline last year. There was a drop of 35% from 1961 in the number of cases. There were 866 cases, including 707 paralytic, reported through November 30.

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Introduction of opaque media into the cranial arterial system, preliminary to cerebral arteriography, or into the vertebral and subclavian systems.
Intraspinal introduction of air preliminary to pneumoencephalography.
Intraspinal introduction of opaque media preliminary to myelography.
Intraventricular introduction of air preliminary to ventriculography.
Insufflation of uterus and fallopian tubes for determination of tubal patency (Rubin's test) or injection of radiopaque contract medium or for dilation.
The following diagnostic procedures, laboratory x-ray (except accident x-ray within 72 hours of the accident) and pathology *are not covered under Federal Employees Program basic Blue Shield* except in the hospital for treatment, but are covered under Supplemental Benefits (80% of cost above $20 on High Option, and 75% above $20 on Low Option.)

Q. If a patient who has been injured is covered under Workman's Compensation, but has exhausted the benefits, will Blue Shield then make payments on covered services performed related to the injury?

A. No payments are made by Blue Shield on Workman's Compensation cases and members are not paying for such protection in their dues.

Q. Some patients insist we report all first aid services: What should be done?

A. When a report is received it is assumed that the reporting physician sincerely believes the services qualify for benefits. The diagnosis and extent of care should be clearly described. It costs $1.50 to process a claim whether it is approved or rejected. Because of this we hope no claims will be submitted for minor first aid treatment or for a service you are positive is not covered in the Blue Shield Contract.

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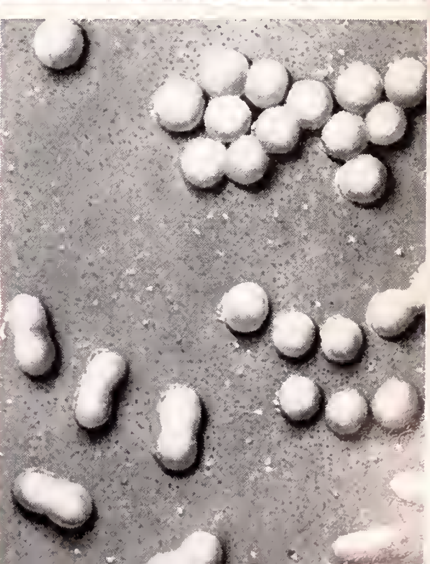

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Emergency Surgery in Chest Trauma

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Newport, Ky.

Physicians are often the only doctors who see acute chest trauma in time to save life. Must they content themselves with supportive measures, or can they rapidly find and stem the exact lethal process?

A recent article in this Journal[1] outlined the role of the physician in trauma to the chest. The present article is intended to complement that picture. A main thesis advanced is that in most cases of chest trauma every physician can supply the surgical procedures necessary to save life. Illustrative cases from the author's practice clarify the thesis.

The Acutely Anoxic Crushed Chest Injury

The patient may be cyanotic or pale; wildly thrashing about in his desperate need for air, or motionless and in shock. This acute anoxia may be due to visible collapse of the fractured chest with inspiration ("flail chest" or "paradoxical respiration"). If the chest wall is not flailing and no injury to the throat is detectable, pneumothorax may be compressing the lung. Again, flail chest *and* pneumothorax may be present concomitantly.

Case 1. H. S., a 29-year-old white male was admitted to Booth Memorial Hospital, Covington, Ky., July 13, 1960, after a steering-wheel injury. B.P. was 60/0. The patient was cyanotic, dyspneic, and exhibited severe retraction of the anterior chest with each inspiration. Large towel clips were clamped through the skin to ribs on either side of the sternum. Manual traction on the towel clips enabled the patient to take several dozen deep breaths. He was grateful for the immediate relief. In the meantime attendants set up pulleys, ropes, and 10 lbs. weight for attachment to the towel clips. Discharged on the 14th day, he has since returned to his usual occupation as a warehouseman. His sole respiratory problem had been the flail chest, and the chest had promptly stabilized.

Case 2. C. T., a 30-year-old white male was admitted to St. Elizabeth Hospital, Covington, Ky., on July 6, 1961, with multiple lacerations and a compound fracture of the right wrist. Pulse was 80 and B.P. 120/80. He complained of chest pain. As x-rays were being taken, he showed evidence of shock, with rapid pulse and intense dyspnea. Hyperresonance was detected over the left chest. Aspiration showed air under pressure. Upon passage of a catheter into the left pleural space through a trochar, large quantities of air issued. His general condition reverted to normal. The catheter was connected to sterile tubing extending to floor level, where the end was placed under sterile water. This allowed continued egress of air; but due to the weight of the water column (or siphon effect), it prevented the intake of air. The compound fracture was debrided and reduced under local anesthesia. Recovery was uneventful. This patient's sole respiratory problem had been tension pneumothorax.

Case 3. S. I., an 18-year-old white female

entered the emergency room at St. Elizabeth Hospital, Covington, Ky., March 30, 1961, after a car wreck. She fought wildly for air, was cyanotic, and frothed at the mouth. Emergency room personnel performed a tracheotomy, but the patient died immediately. Arriving at this juncture, the author opened the left chest. Air under pressure hissed out. A short incision into the right chest also allowed air to issue. Cardiac massage and attempts to expand the froth-filled respiratory tree failed to resuscitate the patient. The patient died of bilateral tension pneumothorax.

Case 4. B. N., a 28-year-old white male, entered St. Elizabeth Hospital, March 24, 1961, after a car wreck. He exhibited superficial chest lacerations and a closed fracture of the right fibula. The general condition was good. Several hours after admission dyspnea developed. There was visible collapse of the anterior chest wall on inspiration. Air was aspirated from the right chest. A catheter was introduced into the chest via a trochar. This was led under a water seal at floor level, where air issued readily. Towel clips were affixed to ribs parasternally for manual (later, weighted) traction. The emergency quickly passed. A long leg cast was applied. Recovery was uneventful. This patient had both pneumothorax and flail chest.

Discussion

Life can be saved in these emergencies. The physician can attach towel clips, buttonhooks, corkscrews, large fish-hooks, large woodscrews, or any available device to ribs or sternum. Manual traction can be applied until better arrangements are available.

Less efficient methods of expanding the flail chest are: Mouth-to-mouth breathing (preferably with an airway) while the patient's nose is pinched shut; the Bennett positive pressure apparatus; or passage of an endotracheal tube with mouth-to-tube breathing supplied by the physician. An anesthetic machine with a breathing bag may be attached to the endotracheal tube with intermittent positive pressure applied manually to the bag. Of course, pure oxygen is introduced into this system.

All these methods expand the lungs, but one must be sure pneumothorax is absent before applying positive pressure to the respiratory tree. Air leaking out of torn lung can rapidly worsen the condition by these internal expansile methods, unless a tube has previously been placed into the chest for egress of air.

When the problem is *tension* pneumothorax, air has to be let out quickly. Pass a needle attached to a well wetted syringe. If the plunger moves outward, tension is present. When a trochar is not at hand, a large needle may be attached to IV tubing. The needle is plunged into the chest and the tubing's open end is placed under water at floor level. This method will not let air out as rapidly as a large catheter and therefore is not fast enough for the desperately anoxic patient.

Given such a patient, *any* measure to let air out of the chest will benefit the situation. Even a quick incision is demanded if time is very short. After an incision has let off the air pressure, the incision may be covered by adhesive tape. Then close watch has to be maintained for another build-up of internal pressure. Of course such an extreme method of relieving tension pneumothorax is reserved for the patient who is rapidly approaching death and cannot wait for better methods.

Delayed Problems After Chest Trauma

In contrast to the acute respiratory problems of chest trauma, delayed problems are often less responsive to therapy. They are especially prone to develop in the obese and the elderly, whose powers of resistance are already worn down. These patients handle lung contusion, pneumonia, cardiac contusion, or fat embolism poorly. There is also an occasional patient whose chest wall does not flail until pneumonia and bronchitis supervene, as in the following two cases.

Case 5. G. W., age 70, a retired farmer, was admitted to St. Luke Hospital with rib fractures, a small left pneumothorax, and closed fractures of the left tibial plateau, the right patella, and the left radius. Abdominal examination was normal. Vital signs were normal and the general condition was good. Under local anesthesia a trochar and catheter were passed into the chest, with the usual tubing led to a water seal. With issue of air, x-rays showed clearing of the pneumothorax.

Although the patient continued to look well, immediate treatment of the fractures would have entailed further (surgical) trauma. Therefore the extremities were immobilized only.

Intra-muscular terramycin in full dosage was started. Regular turning and coughing were supervised. As the general condition remained excellent, on the third hospital day under spinal anesthesia partial patellectomy was done. Long leg casts were applied, and under local anesthesia Kirschner wires were passed through the forearm with incorporation into a long arm cast. Blood loss was 50cc.

Response to surgery seemed good, but six hours later collapse of the chest wall with each inspiration appeared. Rib traction was applied. Tracheotomy facilitated suction of mucus. The abdomen again was normal to examination. Penicillin, streptomycin, oxygen, Alevaire®, and ice-bags were instituted. Eyeground, sputum, and urine examinations revealed no evidence of fat embolism. Three days after surgery he died with the audible rales of bronchopneumonia. Autopsy was not permitted. The fatal course in this aged man is to be contrasted with that of the next case.

Case 6. W. F., a 30-year-old male, was admitted unconscious on March 31, 1962, to the emergency room of St. Elizabeth Hospital. Blood pressure was 80/50 but it fell to unobtainable levels. The chin, mandible, and tongue were crushed. The pharynx was thereby swollen shut. A resident surgeon performed tracheotomy, started 1 liter saline and 1 liter of dextran, administered Vasoxyl® intravenously, and put the patient into head-down position. Respiration was free and full after tracheotomy.

Due to the resident's prompt action the patient's life had been saved. Complete rest was instituted: Fractured metacarpals, forearm, tibia, and fibula were splinted; the compound fracture of the jaw and multiple lacerations were covered with sterile dressings; the patient was left on the emergency room stretcher. In 12 hours consciousness gradually returned, with the adjunctive aid of oxygen and blood transfusion. He was now moved for x-rays. Using only local anesthesia, open wiring of the mandible, and suture of lacerations was done.

At 48 hours exudate aspirated per tracheotomy had become tenaceous. The anterior chest wall was retracting with inspiration. Inspiratory efforts were not bringing air into the chest and cough was not clearing mucus out. Cyanosis and tachycardia appeared. The patient was tired and visibly failing. Rib traction using towel clips was applied. Cough immediately became effective. Oxygen carrying an aerosol detergent was added. As the chest problem was a grave threat, and despite vertebral fractures, the patient was turned periodically from side to side, while maintaining chest traction. The respiratory emergency passed, bronchopneumonia cleared, and recovery followed. As swelling in the pharynx subsided, an ENT consultant was able to see and remove a partial denture from the pharynx. This youthful patient weathered the complications of his crushed chest and pharynx, in contrast to the preceding (elderly) patient.

Permanent Chest Deformity

Noticeable deformity of the chest, even if no hazard to life, is cosmetically undesirable. It has a deleterious psychological effect, since the patient carries a visible reminder of the traumatic episode. And finally, chronic respiratory crippling may ensue. Early restoration of the normal contours is desirable, as delay of a week decreases the chance of success.

Case 7. J. M., a 39-year-old lineman supervisor entered St. Elizabeth Hospital January 27, 1962. His physician found a fractured nose, multiple fractured ribs anteriorly, and a posterior dislocation of the body of the sternum at its joint with the manubrium. As a result the anterior chest wall was visibly depressed. His physician felt elevation was desirable and requested surgical consultation. Under local anesthesia open reduction was achieved using a stainless steel screw across the joint. The body of the sternum and the ribs were elevated by skeletal traction. All external devices were off by the 12th post-operative day. He has returned to his occupation and has no chest deformity.

Penetrating Chest Wounds

Such wounds may injure any organ in the chest or in any area bordering the chest. Thus great vessels at the thoracic inlet may be torn by objects entering the lower chest, organs below the diaphragm by objects entering well up in the chest, etc. One is advised to feel all the pulses, to examine the stomach contents (by Levine tube) and the rectum for blood, to inspect x-rays of the chest, abdomen, and neck, and, if time permits, to measure the hemoglobin and hematocrit.

A rapidly deteriorating patient who has no flail chest or pneumothorax is either exsanguinating internally or has a pericardial blood collection compressing the heart (tamponade). Such a patient demands early exploration, even if blood is not ready. Wounds of the left chest often necessitate laparotomy, while on the right thoracotomy alone usually suffices. The need for laparotomy in left chest wounds arises whenever the stomach, colon, or spleen may have been wounded. On the right, the liver dome may be wounded, but it is only poorly exposed from the abdomen.

Case 8. N. Y., a male, age 12, entered Wm. Booth Memorial Hospital on May 26, 1961 after an accidental stabbing under the left 10th rib posteriorly. Stomach and rectum were free of blood; upright films of the abdomen showed no free air; and chest x-ray showed neither free air nor blood. As the wound was debrided large quantities of blood came forth and the wound seemed to extend into the abdomen across the lower chest.

Immediate laparotomy showed a wounded spleen, which was removed. The diaphragm was found also lacerated, and through this rent a pumping intercostal artery was ligated. The diaphragm was repaired without drainage. Recovery was uneventful. Although the portal of entry was thoracic, abdominal exploration had thus been necessary.

Case 9. L. X., a male, age 35, was brought to St. Elizabeth Hospital, Covington, Ky., August 26, 1961, with no detectible blood pressure or pulse. Breath sounds were audible over both chests. Plasma was given. A stab wound lay *just above the right diaphragm* in the midaxillary line without external bleeding.

Thoracotomy was started at a systolic B.P. of 80. *High near the superior thoracic inlet* the internal mammary artery was bleeding vigorously. After its ligation and the administration of the (now available) blood, his condition improved. The diaphragm and dome of the liver were lacerated but not bleeding. They were repaired and the chest was closed with drainage.

X-rays one week later suggested residual chest fluid. Re-exploration showed no fluid Recovery was uneventful. This patient exemplifies the great distance sometimes found between the sites of entry and of visceral damage.

Case 10. E. I., age 16, entered St. Elizabeth Hospital August 22, 1960. B.P. was 50/30. The pulses waxed and waned with respiration ("paradoxical pulse"). Five punctate shotgun pellet wounds were present over the upper abdomen and precordium. Although the B.P. rose with intravenous fluids, the neck veins were distended and paradoxical pulse continued.

Explorations of the heart and the abdomen were performed under general anesthesia. The pericardium was 2 cms. thick, turgid, and inelastic due to suffusion by massive interstitial hematoma. Two punctate wounds of the right ventricle had stopped bleeding. Sixty cc. of free blood were found in the pericardium. Marked cardiac irritability was manifested by arrhythmia on the slightest manipulation. Two buckshot lay free behind the heart. Paradoxical pulse disappeared on decompressing the pericardium. The pericardium was left open to drain into the chest. The chest was closed with drainage. Laparotomy was negative. Recovery was complete. The patient demanded cardiac exploration for paradoxical pulse and distended neck veins.

Case 11. D. E., a male, age 44, entered Booth Memorial Hospital, Covington, Ky. August 19, 1961, after being shot twice in rapid succession with a .22 automatic. A bullet wound with powder burns overlying the precordium was matched by a single hole over the left posterior chest. Police had found one bullet in a wall at the scene of the shooting. A second bullet lay posterior to the heart, and the pathways apparently traversed the heart.

When he was moved for x-rays his B.P. fell and cardiac arrhythmia appeared. On lying still the arrhythmia stopped. Venous pressure was measured and was normal (7 cms). Blood counts did not suggest hemorrhage. Since the difficulty seemed myocardial damage (rather than hemorrhage or tamponade), surgery was deferred. It appeared that anesthesia would compound the myocardial irritability while offering no conceivable operative advantage to the damaged muscle, to the conductive system, or to the coronary circulation.

He was observed some hours at absolute rest in surgery with a defibrillator and instruments for quick cardiac massage at hand. An electrocardiogram showed posterior ischemia which

reverted to normal over nine days' time. Massive subcutaneous emphysema from scalp to groins later appeared. As there was no significant pneumothorax, no treatment was required. Discharged at three weeks, this patient has returned to heavy work without difficulty.

Nice judgment may be needed in deciding whether cardiac wounds demand surgical intervention. The prime indications are: 1) A pulse that waxes and wanes with respiration, reflecting tamponade; 2) hypotension, reflecting cardiac hemorrhage. The ideal treatment for tamponade, *especially if neck veins are distended,* is surgical decompression of the pericardium. But in a rapidly deteriorating tamponade victim, time may be gained by aspiration. Using a large caliber needle alongside the left side of the sternum, or angling upward through the diaphragm from alongside the xiphoid, one may save life for a while at least, and little added harm can be done even if the myocardium itself is needled. The cardiac wound that bleeds massively but is uncomplicated by tamponade, can be helped only by early exploration, even if blood is not available.

Cardiac arrhythmia due to trauma (as in the last case above or in cardiac contusion) is best let alone. Quinidine may be given. Equipment for defibrillation or massage are kept at the bedside. A baseline EKG is needed in suspected cases, to evaluate later EKG changes. In non-penetrating wounds, cardiac contusion is by some authorities treated by anticoagulants.

Summary

1. The more common forms of chest trauma are presented.

2. Emergency measures possible to all doctors are outlined.

3. Illustrative cases from the author's practice are presented.

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Lung Abscess

C. H. Rivarola, M.D.; N. Levene, M.D.; A. Bautista, M.D.*

Louisville, Ky.

Lung abscesses encountered over a six-year period in a tuberculosis sanatorium are reviewed. Etiology, pathogenesis, symptoms, and diagnosis of lung abscess are discussed. Prevention, as well as medical and surgical treatment, with our results is presented.

In recent years lung abscess has become one of the major problems in differential diagnosis in tuberculosis sanatoria. Thirty cases have been found at the District Two Kentucky State Tuberculosis Hospital from April 1956 through April 1962. Classification, etiology, pathogenesis, symptoms, method of diagnosis, location, and bacteriology will be discussed. A review of our cases will be given.

Lung abscess is an area of localized suppuration and cavity formation within the parenchyma of the lung. The widespread use of antibiotics has produced a marked change in the morbidity and mortality rate of various types of pulmonary infections. In many instances, therapy with antibiotics has resolved the abscess. If such therapy fails to resolve the abscess, it is possible to reduce the amount of inflammatory reaction and localize the process in order for the surgeon to do excisional surgery. Excisional surgery, when indicated, has proven to be far superior to external drainage of the abscess.

Classification

Pulmonary abscesses usually are divided into three groups. (A) Acute. This refers to a process of six weeks' duration or less. (B) Subacute. This refers to a duration between seven to twelve weeks. (C) Chronic. This concerns those cases in which the abscess has been present over 12 weeks.

Etiology

Numerous etiologic factors may play a role in the formation of the pulmonary abscess. Several years ago, Brock reported that the most common cause of lung abscess was aspiration. In the most recent reports in the literature on this subject, bronchial obstruction due to neoplasm with a pneumonic process proximal to that obstruction has been the leading cause of lung abscess. In any event, bronchial or bronchiolar obstruction due to foreign body, carcinoma, inflammation, and aspirated secretions leads to an area of atelectasis which, when infected, leads to abscess formation, necrosis, and suppuration. We elected to divide the etiological factors into the seven groups most commonly encountered.

Group A — Aspiration. In this particular group we encountered patients under the most variable circumstances; for example, those with loss of consciousness due to diabetic acidosis, alcoholism, epilepsy, anesthesia, absence of cough reflex, and patients after tonsillectomy or dental extraction. We must also include in this group patients with esophageal and pyloric obstruction. In this group, secretions as well as vomitus are the most common agents. Particularly in children, foreign bodies such as peanut shells and beans may be causative.

Group B—Neoplastic. This etiologic factor must be seriously considered in any patient, particularly males between the ages of 40 to 60. Bronchogenic carcinoma frequently appears on x-ray as a lung abscess. In some of our patients the first sign of an advanced bronchogenic carcinoma was the presence of an abnormal x-ray finding compatible with a lung abscess. Some of these patients will appear to improve after a course of antibiotics, as the inflammatory reaction at the periphery of the malignancy decreases. However, it must be realized that these patients should be treated surgically if considered operable.

* *From the Department of Thoracic Surgery, State Tuberculosis Hospital, Louisville, Ky.*

TABLE NO. 1
Etiological factors in lung abscess

	Cases
Pneumonia	16
Carcinoma	4
Bronchiectasis	4
Aspiration	3
Infarction	2
Metastatic	1
	30

Group C—Pneumonic. We will not include in this group those patients in whom the pneumonic process is secondary to a bronchial obstruction due to malignancy. We are referring in this group to those patients in whom the first pathological process in the lung is a pneumonia. In our group of patients this represents the largest number—over 50%. In adults the Klebsiella type of pneumonia commonly reaches the stage of suppuration and necrosis. In children, it is common to encounter the Staphylococcic type of pneumonia with multiple abscesses. Any kind of pneumonic process may lead to abscess formation if it is improperly treated.

Group D—Bronchial. We include in this group patients who develop a lung abscess because of bronchiectasis. We have four such patients in our study and as bronchiectasis is most common in the lower lobes, this type of abscess is most commonly located in the lower lung field. There must be included in this group also the bronchopulmonary sequestrations and intraparenchymatous abscesses secondary to empyema with bronchopleural fistula. In bronchopulmonary sequestration the bronchial tree is hypoplastic and the sequestrated area always ends in blind sacs that easily become infected because of the non-functioning lung.

Group E—Metastatic lung abscess. We have a patient in this report who died from a lung abscess that was secondary to a periurethral one. This group includes patients with septic embolism from thrombophlebitis.

Group F—Direct extension. This group includes such rarities as direct extension from Pott's abscess, osteomyelitis of a rib, mediastinal abscess, and subphrenic abscess.

Group G—Traumatic. This group is very uncommon in this day, but during the war and in the pre-antibiotic era this type of lung abscess was quite common.

Pathogenesis

Commonly lung abscess has been thought to occur most often in the lower lobes, so much so that even experienced clinicians are sometimes skeptical of accepting a diagnosis of lung abscess when the lesion is in an upper lobe. However, they do occur with great frequency in the upper lobes, although a lesion in this position should have a full workup in order to exclude pulmonary tuberculosis. Observers have attempted to explain this incidence of upper lobe abscess.

Brock has endeavored to show that the causative factors responsible for the development of an abscess in any particular site in the lung are chiefly inhalation and posture.[15] He explained that when the patient is lying wholly or partly on his side the most favorable site for inhaled material to gravitate is in the lateral portion of the upper lobes, more especially on the right and when the patient is lying on his back the apical branch to the lower lobe is the first bronchus encountered by the material flowing along the posterior wall.

Factors Responsible

Factors responsible for lung abscess, as has been mentioned previously, differ somewhat after nose and throat operations and after abdominal operation. After an operation on the nose or throat the patient is not only lying down, but is oftentimes turned towards one side, usually the right. It is in this position of recumbency that inhalation of blood clot or other material from the pharynx is so liable to occur. After an abdominal operation the patient is also kept lying down until he can be raised to a Fowler's position, but it is uncommon for blood clot or other material to be in the pharynx unless from the trauma of a gag or some irritation in the throat. The chief source of infection of the lung after laparotomy is a preexisting bronchial infection, the development of which is favored by ineffective cough and tight bandaging. M. W. Wolcott and J. D. Murphy[7] have explained the pathogenesis and etiology on the basis of bronchial or bronchiolar obstruction which lead to an area of atelectasis, followed by infection. Subsequently, vessels become thrombosed, leading to infarction. Infection plus infarction leads to tissue necrosis and suppuration.

Symptoms

The symptoms of lung abscess are variable but the most commonly encountered are cough, production of copious amounts of purulent sputum, chills, fever, sometimes hemoptysis, weight loss and chest pain. The duration of these symptoms is also quite variable. We found some of our patients completely asymptomatic, the abscess having been found in a routine chest x-ray. In most of the patients admitted to the hospital, the history varies from two weeks to about five months' duration. A careful history, as well as physical examination, should be done at the time of admission. It often is possible to obtain information about the onset of the process and the symptomatology that will suggest pulmonary abscess. On the other hand, if the patient has a long history of chronic pulmonary disease some of the symptoms could certainly be related to the other diseases and sometimes bronchiectasis, tuberculosis, or fungus disease should be considered as an associated disease. Before treatment, the sputum is usually foul smelling. Some patients learn that in certain positions it is much easier to cough and get better drainage of the abscess.

In our group of patients, in which over 50% started with a pneumonic process, fever and chills had occurred several weeks prior to admission to the hospital. Weight loss, as well as chest pain, are significant findings and in many patients this picture well could be a neoplasm. In children, chest pain did not appear to be a significant complaint. In some of our patients, fatigue, malaise, and night sweats were present but in most of the cases there was an associated disease that explained these symptoms.

Methods of Diagnosis

It is impossible to overemphasize the importance of a good history in these patients. There are several questions the patient should be asked. For instance, inquire about dental surgery or any other surgery in the mouth or neck. In the alcoholic, as well as epileptics and diabetics, it is important to know if there has been loss of consciousness. Dental hygiene should be evaluated in any case of possible lung abscess.[4]

After a complete history and physical examination have been obtained, an accurate record of the temperature of these patients before they are placed on antibiotics is important. It is a good routine to check the pulse as well as the temperature every four hours when the patient is awake. Patients should be instructed how to collect sputum and the importance of the first morning sputum should be stressed. The amount of expectoration, the color, the odor, as well as presence or absence of blood, should be recorded in the nurses' note. Sputum should be sent to the laboratory for Papanicolaou studies as well as for smears and cultures for acid fast bacilli, fungi and pathogenic organisms, including sensitivity studies.

Pulmonary Abscess

In patients with pulmonary abscess, bronchoscopy serves as a method of diagnosis and a method of treatment. The latter will be discussed later. Through the bronchoscope it is possible to detect the cause of obstruction if it is present in reachable areas. Carcinoma, adenoma, foreign bodies, plugs of mucus and blood, abnormal bands or other obstruction in the tracheobronchial tree may thus be diagnosed with the bronchoscope. Bronchoscopic aspiration permits us to obtain uncontaminated secretions from the tracheobronchial tree. This material may yield malignant cells, an etiological organism, and more accurate sensitivity studies. These two last points must be emphasized as some of these patients are very weak and unable to cough effectively enough to obtain secretions from the tracheobronchial tree. The specimens may come only from the mouth, or from the larynx.

The final method of diagnosis we want to mention is the bronchogram,[8] which may show areas otherwise not visible.[7] The bronchogram is also of value as a permanent record which may later help the surgeon obtain complete excision of the abscessed area.

Site of the Abscess

In this series of patients, as well as in many others published, the right lung is more commonly the site of the disease than the left. This is explained by the anatomy of the right main bronchus. Second in frequency is the posterior segment of the upper lobe on the right and then the superior segment of the right lower lobe. In children, apparently, abscess of the right middle lobe is more frequent than in other sites.[10]

Bacteriology

It is stated in the literature that lung abscesses are frequently of mixed infection. This was true in this series of patients. In most of the series reported there is a large number of gram negative organisms. One also notes reports of change from a gram positive organism to gram negative or from gram negative to gram positive. Persistence of the presumed initiating pathogenic organism is rare. The most commonly found organisms are Alpha streptococcus, Beta streptococcus, staphylococcus, Klebsiella pneumoniae, Hemophilus influenzae, Neisseria and Pseudomonas aeruginosa.

Present Report

Thirty cases were studied. Twenty-five of these were males and five were females. Cases with minute embolic abscesses, infected congenital cysts, and large tuberculous cavities with superimposed infections were not included in this report. The ages ranged from 28 to 74 years. Sixty per cent of our group (18 cases) were between 50 and 60 years of age. In 25 cases the abscess was single and in five cases there were multiple abscesses.

The clinical picture of lung abscess has been described. The duration of symptoms in our patients varied from two weeks to one and one-half years. However, in 66% the history of malaise, fever, large amount of expectoration, and chest pain was no longer than 10 to 12 weeks. In one case, there were no symptoms and the abscess was discovered on routine chest x-ray.

Sixteen of our patients (53%) started with a typical picture of a pneumonic illness, which was inadequately treated. In four patients (13%) carcinoma was the etiological factor in the development of the lung abscess. Some series report carcinoma in as high as 44% of the cases.[1, 2] Table No. 2 shows the location of the abscess. As with most series, the right lung was the most common site.

TABLE NO. 2
Location of abscess

	Cases
Right upper lobe	14
Right lower lobe	6
Left upper lobe	6
Left lower lobe	3
Right middle lobe	1
	30

TABLE NO. 3
Organisms most commonly found in bronchi or sputum of patients in this series

- Hemolytic Streptococcus
- Hemolytic Staphylococcus albus coagulase positive
- Hemolytic Staphylococcus aureus
- Candida albicans
- Micrococci
- Pseudomonas aeruginosa
- Fungus (Geotrichum)

Bacteriological studies for tubercle bacilli were done routinely. Since this is a tuberculosis institution, organisms other than the tubercle bacillus were identified in only 50% of the cases. The specimen was obtained in some of the patients by bronchoscopic examination and in some of the patients only sputum examination was done. The most commonly found organisms are listed in Table No. 3.

Watterman, Domm, and Rogers reported that 19% of their cases were secondary to some other primary serious disease.[2] Other authors have made similar reports.[2, 13, 14] Our results are in agreement with these reports. (See Table No. 4.) Sixteen patients of the 30 suffered from an associated disease such as epilepsy, diabetes, chronic alcoholism. Associated pre-existing pulmonary disease appeared to exert an important influence on both the development and the treatment of the lung abscess.

TABLE NO. 4
Associated diseases in 16 of 30 patients

	Cases
Pulmonary tuberculosis	5
Epilepsy	4
Diabetes mellitus	3
Chronic alcoholism	3
Periurethral abscess	1
	16

Treatment

Several years ago Doctor Watterman noted three fallacies about lung abscess that we believe are important to remember. First, the lung abscess is so rare that it is no longer of importance. Second, medical treatment alone suffices in practically all of the few cases. Third, resection is the only surgical treatment of value. We certainly agree with his concepts.

In recent years the pendulum has swung from surgery to medical treatment and a number of reports indicate that lung abscess should be considered primarily a medical problem. We

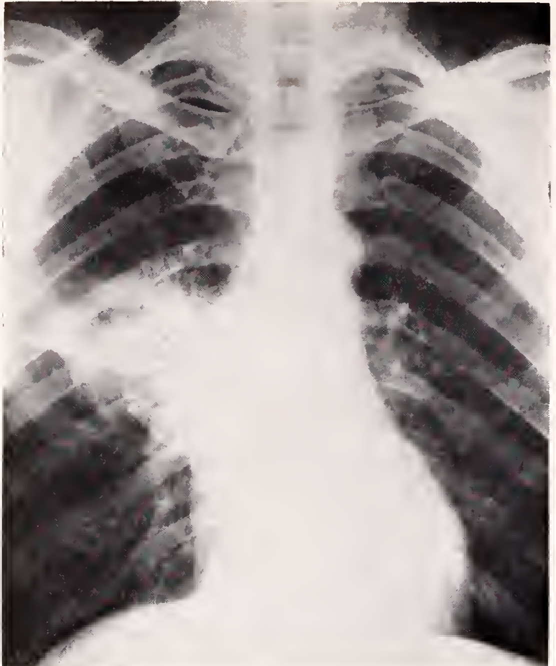

Figure 1.: X-ray of a patient with lung abscess in the superior segment of the right lower lobe.

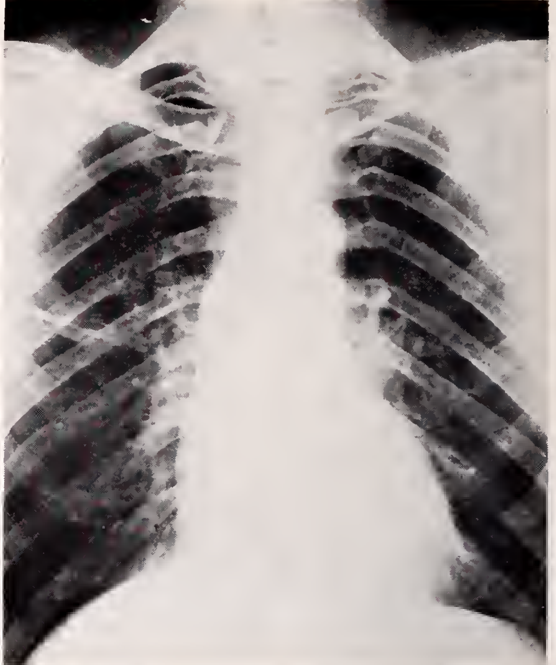

Figure 2.: X-ray of the same patient, treated medically for a period of eight weeks.

believe that the correct answer is that of medical-surgical treatment. First, medical treatment for at least five or six weeks, and then, if there is no definite improvement, surgical treatment should be considered. It is impossible to draw a line between a pure medical treatment and a pure surgical treatment for lung abscess because both methods of treatment overlap at certain points. However, in order to explain what we consider medical treatment we list the following:

Medical Treatment.

A. Observation, admission to the hospital, and frequent chest x-rays.

B. Chemotherapy. We advise the use of at least two antibiotics. One should be penicillin and the other, one of the broad spectrum antibiotics with sensitivity studies being used as a guide.

C. Hydration.

D. Parenteral enzymatic therapy (Crystalline pancreatic desoxyribonuclease).

E. Supportive therapy, including vitamins and blood transfusions.

F. Bronchoscopy. Here is where medical and surgical treatments overlap. Bronchoscopy is a surgical procedure we believe essential in the diagnosis as well as in the therapy of lung abscess.

G. Postural drainage.

H. Aerosol therapy, particularly with the use of trypsin. Recently, there have been several reports of the use of trypsin in aerosol therapy with very satisfactory results.[6]

In this group of 30 patients, 19 have been treated with medical treatment consisting of most of the above mentioned forms. Since all of our patients were in a tuberculosis hospital, they were given antituberculous drugs also. All received penicillin as we felt this was the drug of choice, plus one of the broad spectrum antibiotics, preferably chloromycetin or tetracycline. Periods of treatment ranged from five weeks to several months.

Surgical Treatment

(1) Bronchoscopy is the first step in the surgical treatment of a patient with lung abscess.[9] With this procedure it is possible to demonstrate the cause of obstruction, relieve it, and facilitate drainage. The high frequency with which bronchogenic carcinoma has been found in patients with lung abscess is in itself an indication for diagnostic bronchoscopy.

(2) Catheterization of the bronchus. Metras, in France, has described a method of satisfactory drainage of abscess by catheterization of the bronchus.[3] We have no experience with this method and apparently it has not yet become popular.

(3) Postural drainage. This is a part of the

medical as well as the surgical treatment for lung abscess. In the surgical field postural drainage has a place immediately after the bronchoscopy. Usually these patients drain a large amount of mucopurulent material.

(4) Antibiotics. Antibiotics should be given in accordance with the report of the sensitivity studies.

(5) Open drainage. Several years ago the surgical treatment of lung abscess consisted only of open drainage. In this group of 30 patients we have only one patient to whom we applied this form of surgical treatment.

(6) Pulmonary resection. At the present stage of thoracic surgery, pulmonary resection is the ideal method of surgical treatment of lung abscess. In this series 11 patients were treated surgically. Ten of these underwent excisional surgery. (See Table No. 5.) Lobectomy was the most common procedure. All patients who received surgical treatment except one received medical treatment for at least five weeks prior to surgery.

Results

In this group of patients with lung abscess two-thirds were treated medically and one-third were treated surgically. There were 19 patients treated medically with a mortality of two (11%). Eleven patients were treated surgically.

TABLE NO. 5

Procedures in 11 patients treated surgically

	Cases
Lobectomy	6
Pneumonectomy	2
Segmental resection	1
Exploratory thoracotomy	1
Open drainage	1
	11

Three of these died with lung cancer in the late postoperative period, a surgical mortality of 27%.

These figures are quite similar to other reports. For instance, Moore, Anderson, and Khlar reported 90 cases, 12% of whom were treated medically. The results of our medically and surgically treated cases are listed in Table No. 6. In the group of 19 patients treated medically, 8 recovered, which means 42% of the total. In the surgical group 6 of 11 patients recovered (54% of the total group). In the medical group two patients are doing poorly. One is a 72-year-old patient who refused surgery and whose general condition is deteriorating. The other patient has an infected pulmonary infarction and his general condition is still not satisfactory for surgical treatment. In the group of patients treated surgically, one developed a bronchopleural fistula after a pneumonectomy for multiple abscesses in the left lung. (Table No. 6 is on next page.)

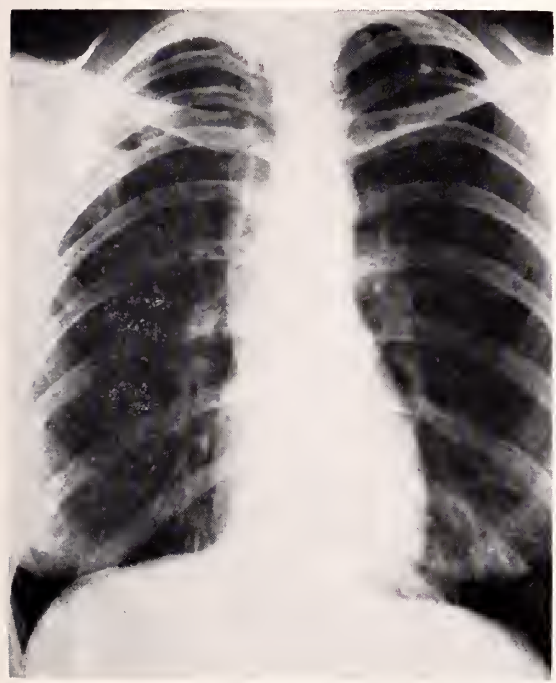

Figure 3.: X-ray of a patient with lung abscess in the right upper lobe.

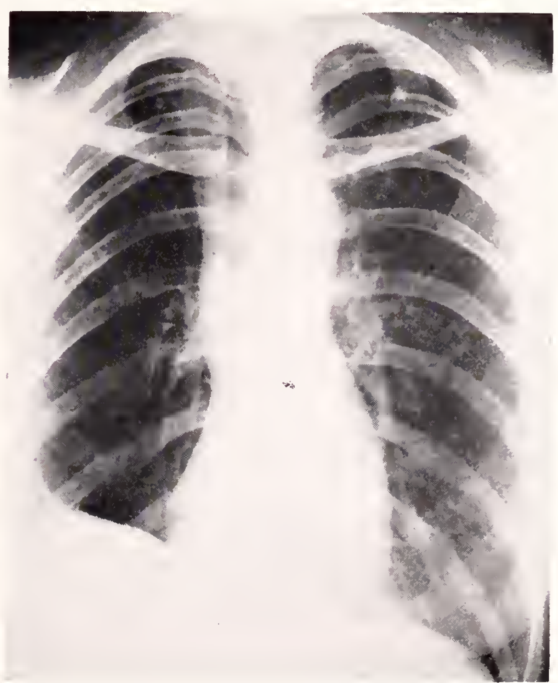

Figure 4.: X-ray of the same patient after right upper lobectomy.

TABLE NO. 6
Results

Patients Treated Medically		Patients Treated Surgically	
Doing well	8	Doing well	6
Still in hospital	2	Still in hospital	0
Doing poorly	2	Doing poorly	1
Died from abscess	2	Died from cancer	3
Died of tuberculosis	1	Died of tuberculosis	1
Unknown	4	Unknown	0
	19		11

Summary

A group of 30 patients with lung abscesses is presented. The overall mortality of the entire group is 16%. Good results were obtained with surgical treatment if the lesion was not due to cancer. All the patients were treated with medical treatment first and if definite improvement was not noted after at least five to six weeks of treatment, surgical treatment was advised. We believe the ideal treatment of lung abscess is medical, however, bronchogenic carcinoma should be considered as one of the etiological factors and as such, the only definitive treatment is surgery. In over 50% of this group, the abscess started as a pneumonic process. Besides the report of the 30 patients, a review of the etiology, pathogenesis, and treatment of lung abscess is given.

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The Complete Program

for the

1963 KSMA INTERIM MEETING

March 7 at Covington

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The Journal

Ciliated Epithelial Esophageal Cyst—A Case Report

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There are two types of ciliated epithelial cysts in the mediastinum, the bronchogenic and the esophageal cysts. The latter is different from the enterogenic and gastrogenic cysts in the structure of the lining epithelium.

CILIATED epithelial cysts of the mediastinum constitute an interesting group of congenital anomalies which are correctable by surgical excision. Maier[8] has labeled all ciliated epithelial mediastinal cysts as bronchogenic, although he admits some of the esophageal cysts may have a separate origin. However, two groups are distinctly separable according to their anatomical location. The commonest type is found in the region of the tracheal bifurcation or the main stem bronchi. The second, less common type of the ciliated epithelial cysts occurs in the wall of, or adjacent to the esophagus and has been variously labeled, "esophageal," "foregut," "paraesophageal bronchogenic," or "ciliated epithelial esophageal" cyst.

Embryologically,[2] the lower respiratory tract first becomes apparent at the fetal age of 24 days, at which time a thickening develops in the ventral wall of the foregut. This thickening ultimately develops into the right and left lung buds. As the lung buds elongate, the respiratory portion of the gut separates from the esophageal portion by lateral ingrowth of the surrounding mesoderm which meets progressively to form a tracheo-esophageal septum. During this process of development, nests of cells may be pinched off or sequestrated from either foregut or the primitive respiratory tract and develop subsequently into isolated cysts. Cysts developed from the foregut are the "foregut cysts" or "ciliated epithelial esophageal cysts," and those derived from the ventral respiratory tract are the "bronchogenic cysts."

Because of rapid elongation of the esophagus at the time of descent of the heart, the esophageal cysts are usually located in the lower third of the esophagus. Histologically, they are composed of a lining epithelium of pseudo-stratified, columnar, ciliated cells resting on a layer of submucous connective tissue, which may contain glandular structure and some smooth muscle. Plates of hyaline cartilage are occasionally found within the walls of the cysts. The lumen is filled with a grayish viscid fluid. Though these cysts are said[3] not to communicate directly with the lumen of the esophagus, a rare case which had direct communication with the mid-esophagus has been reported.[5]

The first report of an esophageal cyst was made by Wyss[3] in 1870 who described a tumor in the posterior wall of the esophagus. In 1954, Creech and DeBakey[3] collected 49 cases of ciliated epithelial esophageal cysts in the literature. Recently, an increasing number of such esophageal cysts have been reported in the world literature under various names. Creech and DeBakey warn that the anomalies which have been described are not to be confused with the enterogenous or gastrogenous cysts occasionally found in the mediastinum, often attached to the esophagus. The enterogenous and gastrogenous cysts generally contain all the normal structural elements of the stomach or intestinal tract, including a *functioning* lining epithelium and secrete gastric or intestinal juice. Consequently, they are almost never asymptomatic[12] and 75% of them are discovered in the first year of life.[10]

Recently, I operated on a patient who had had an asymptomatic cystic mass in the posterior mediastinum which was found to be a ciliated epithelial esophageal cyst. Because of the rarity of this congenital anomaly, the case is reported herein.

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Report of the Case

E. R., a 43-year-old white man, who has been at the Lexington Veterans Administration Hospital since 1943 with the diagnosis of schizophrenia, was found to have a mass in the left chest by a routine chest x-ray film in January 1962. Review of previous films showed this mass to have been present since 1950 during which period it was unchanged in size. The patient had been entirely asymptomatic and healthy during his hospitalization.

Physical examination failed to reveal any abnormalities except edentia. Roentgenographic examination of the chest and an esophagogram demonstrated a 6 x 7 cm., sharply circumscribed soft tissue mass in intimate association with the left diaphragm. This mass lay immediately

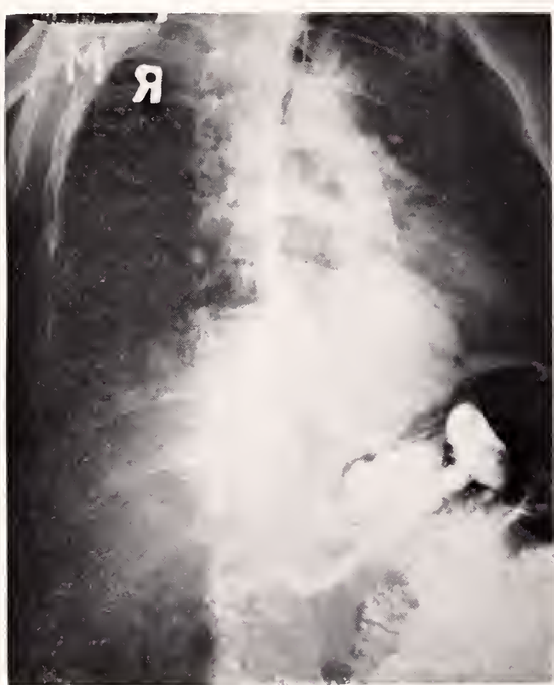

Figure 1.: Sharply circumscribed soft tissue mass in intimate association with the left diaphragm and immediately to the left of the esophagus.

to the left of the esophagus but did not appear to interfere with swallowing (Figure 1). Pericardial cyst, bronchogenic cyst, esophageal cyst and cystic lymphangioma were all considered in the differential diagnosis. Bronchogenic cyst was the favored diagnosis.

On March 8, 1962, an exploratory thoracotomy was carried out through a left posterior lateral incision, the chest being entered through the bed of the sixth rib. There was a cystic mass located between the distal surface of the left lung and the left diaphragm. Dissection from

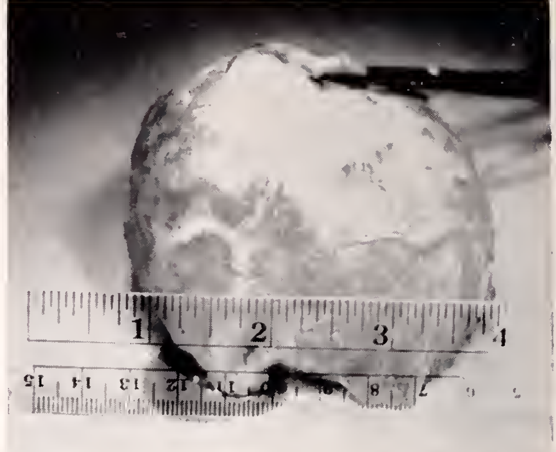

Figure 2.: The round smooth mass after excision, 8 cm. in diameter. Contained gray greenish viscid fluid.

the lung and diaphragm was easy and no direct communication between the mass and the lung was present. The mass was densely adherent to the esophagus, and great care was required to excise it without entering the esophageal lumen. The esophagus both above and below the mass was mobilized and encircled with tapes, following which the mass was carefully dissected free from the underlying esophageal mucosa. Following excision of the mass esophageal mucosa was bulging through the split muscular layer and the muscularis was approximated with interrupted silk sutures over the intact mucosa as a buttress.

The mass was round and contained gray greenish viscid fluid (Figure 2). Culture of this fluid grew no organisms. Convalescence was uneventful and the patient returned to his mental ward on the 10 postoperative day.

Pathologic report: The specimen consisted of a thin-walled sac that measured 8 cm. in diameter and 1 mm. in thickness. The external surface was granular and fibrous and contained

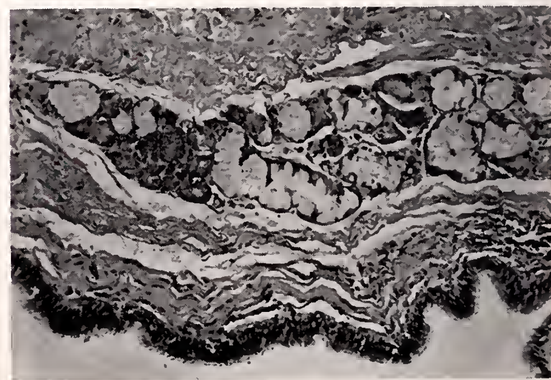

Figure 3.: Microscopic picture of the internal surface, lined with pseudostratified ciliated columnar epithelial lining and mixed mucoserous glands.

small portions of yellow lobulated fat. Portions of the internal surface were opaque gray, smooth and glistening. Other portions were trabeculated. Microscopically, there was a pseudo-stratified ciliated columnar epithelial lining and mixed mucoserous glands. There were well differentiated smooth muscle bundles but no hyaline cartilage in the cyst wall (Figure 3).

Summary

The case of a 43-year-old white male, having a large asymptomatic ciliated epithelial esophageal cyst is presented. The epithelial lining of the cyst consisted of pseudo-stratified ciliated columnar epithelium of the respiratory type. The theory of the development of this rare congenital anomaly is discussed and the literature is reviewed. The entity of ciliated epithelial esophageal cyst should be kept in mind in the differential diagnosis of a smooth round posterior mediastinal lesion. At thoracotomy careful dissection of the cystic mass should be observed in order to avoid penetration into the lumen of the esophagus.

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The Organization Chart for the KENTUCKY STATE MEDICAL ASSOCIATION Revised as of January 1 Is on Page 158

Current Problems in the Surgical Treatment of Congenital Heart Disease* **

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Surgical problems related to correction of extracardiac anomalies are usually a result of complications from delay in repair of these lesions. Many problems related to the intracardiac abnormalities are due to complicated anatomy or very small size of the infant's heart.

CONGENITAL anomalies of the heart and great vessels constitute a complex group of abnormalities which result in a variety of circulatory disturbances. For convenience these congenital defects may be divided into conditions which occur outside the heart and those which occur within the chambers of the heart. This is a significant division because the extracardiac abnormalities may be treated without complicated machinery or large cardiovascular teams but the intracardiac defects require a more elaborate surgical attack.

Extracardiac Defects

There are three common forms of extracardiac congenital heart disease. The rarest of these is the *congenital vascular ring* which is usually detected in the newborn. The most significant factor in the treatment of this abnormality is early diagnosis. A high index of suspicion in any infant with respiratory or swallowing difficulty will lead to the diagnostic x-ray studies. The major problems in the operative correction of this defect are related to the dangers of anesthesia in the small infant with respiratory distress, and the extent of aspiration pneumonia which has developed in the period of delayed diagnosis. Surgical division of the constricting vascular ring is a standard technical maneuver with an excellent postoperative prognosis.

The *patent ductus arteriosus* is a more common abnormality and is usually easily diagnosed. Problems in diagnosis occur only when the classical continuous murmur is missing. This atypical ductus murmur, which is systolic with or without a short diastolic component, can be clarified with retrograde aortography or other contrast radiography.

In some cases the absence of a diastolic murmur is a reflection of increased resistance in the pulmonary vascular bed and the development of secondary pulmonary hypertension.[3] This remains the single most serious problem in the surgical treatment of patent ductus arteriosus. The elevated pressure in the lungs results from organic changes in the walls of the pulmonary arteries. These changes are in turn related to the increased flow of blood in the pulmonary system brought about by the left-to-right shunt through the patent ductus. The alterations in the pulmonary vessels may become so advanced that the pressures on the two sides of the ductus are equalized. The pressures then become balanced and eventually there may be a reversal of the shunt, from the pulmonary artery into the aorta.

Concomitant with these changes the patent ductus enlarges as does the pulmonary artery and the technical problems of division of the patent ductus become formidable. In addition atheromatous degeneration of these vessels makes handling and dissection treacherous. If these processes are allowed to progress to the point of fixed reversal of flow in the patent ductus, the patient is no longer a candidate for surgical division of the patent ductus.[4] At this point, the ductus is acting as a pop-off valve for the markedly elevated pressure in the pulmonary artery.

Presented before the First Trustee District Meeting of the KSMA during Heart Day Program of Calloway County Heart Association in Murray, Ky., February 8, 1962.

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This very serious clinical situation and difficult surgical problem can be prevented by early recognition and correction of the patent ductus before the development of these secondary changes in the pulmonary vessels.

A third common extracardiac abnormality is *coarctation of the aorta*. The diagnosis of this condition is classically made in the child or young adult with hypertension in the upper extremities and weak or absent pulses in the lower extremities. The presumptive diagnosis can be verified by aortography. In the unusual case extensive hypoplasia of the aorta may result in a long segment of markedly narrowed and deformed aorta. This may extend from the aortic arch to the abdominal aorta and may necessitate replacement of the aorta with a plastic prosthesis.[5]

Complications associated with long standing hypertension are more common than hypoplasia. These may take the form of atherosclerotic plaques in both proximal and distal aorta, of aneurysmal dilation of the aorta, of dissection of the aortic wall, or of friable intercostal collateral vessels. All of these may contribute to technical difficulties in the resection of the coarcted segment and in the anastomosis of the two ends.

Aside from the changes in the blood vessels themselves, there is the ever present threat of subacute bacterial endocarditis. All of these problems, except hypoplasia of the aorta, may be circumvented by early operation before the development of degenerative changes or bacterial infection.

Intracardiac Defects

The surgical treatment of intracardiac congenital abnormalities was first carried out with varying degrees of success by blind manipulation through the walls of the heart. Most of the completely corrective procedures have awaited the development of refined techniques of extracorporeal circulation. Since Lillehei reported his preliminary results with parent-to-child cross perfusion in 1954,[6] a vast array of heart-lung machines has been introduced. The basic ingredients of all by-pass techniques are, first, an efficient blood oxygenator which will not damage the circulating red blood cells and, second, a pumping or propelling mechanism which will circulate the blood through the oxygenator and return it at arterial pressure to the patient. A high degree of precision has been attained in this field but there remain many problems related to the injury which results to the circulating red blood cells, to changes in the water-electrolyte composition, and to the metabolic changes in the many organ systems which are artificially maintained during the open heart surgery. These constitute current surgical problems which are beyond the scope of this paper.

Intracardiac congenital abnormalities may be divided into defects of the septa of the heart, into defects of the valves and outflow areas of the heart, and finally into a combination of these defects. Openings in the interatrial septum are more common than abnormalities of the interventricular septum. Defects in the interatrial septum fall into two major groups. One is the *ostium secundum* type which is characterized by a relatively central opening in the interatrial septum with margins of normal septum around it. It is the commonest interatrial septal defect and is functionally a left-to-right shunt. The major problem associated with the ostium secundum defect is its association with anomalous drainage of the pulmonary veins. This combination creates a technical problem of closing the defect and of rerouting the pulmonary venous drainage into the left atrium. This can be accomplished in most cases without difficulty if the anomalous drainage is recognized.[7] Occasionally the opening may lie so high in the septum that it involves the drainage of the superior vena cava. The potential problem of constricting the superior vena cava in the process of closing the defect may be troublesome. This may necessitate the use of plastic material to enlarge the inflow area of the superior vena cava.

The *ostium primum* defect is a more complicated anomaly because it is often associated with maldevelopment of the tricuspid and mitral valves.[9] The usual associated defect is a cleft mitral valve with mitral insufficiency. There is no inferior rim of septal tissue. A plastic patch is necessary to bridge this gap.

Another vexing problem with the ostium primum defect is the proximity of the atrioventricular conduction system which must be avoided. Operative atrioventricular dissociation or complete heart block remains one of the serious hazards in the repair of these defects. Sev-

eral methods of vital staining of this conduction bundle have been introduced but none is foolproof. The most dependable means of avoiding this conduction pathway is to close the defect while the heart is beating regularly and while the electrocardiogram is being monitored continuously. Any acute change in the electrocardiogram reflects the placement of a suture within or too near the conduction apparatus. The offending suture is then promptly removed.

A second group of defects occurs in the ventricular septum. They may lie near the pulmonary valve in the membranous septum or they may occur in the muscular portion of the septum. The membranous defects pose no serious technical problems as they can usually be closed by direct suture. The edges of the muscular defects, on the other hand, will not support the suture material and cannot be closed directly. In these cases a Teflon felt or woven prosthesis is used to bridge the defect.

The most serious remaining problem in the surgical correction of ventricular septal defects is associated pulmonary hypertension. The pathogenesis of this secondary hypertension is similar to that resulting from a patent ductus, namely, prolonged left-to-right shunting of blood into the pulmonary vasculature with resultant organic changes in the walls of the pulmonary arteries. If the pressures on the two sides of the defect become equal, a right-to-left shunt will occur. This is the so-called Eisenmenger syndrome.

The postoperative mortality increases with the degree of pulmonary hypertension. The open heart surgical repair is well tolerated but in the immediate postoperative period there remains a high resistance to blood flow through the lungs. In a very high percentage of cases acute cor pulmonale and right-sided failure occur. Positive pressure respirators have been helpful in decreasing this postoperative complication by maintaining optimum ventilation and oxygenation. The obvious answer to this troublesome problem is earlier diagnosis and repair.

The size of the patient remains a very definite factor in the handling of intracardiac abnormalities, particularly an interventricular septal defect. A small infant is poorly adapted to the volume characteristics of extracorporeal circulation and the small structures may make the technical aspects of the operative procedure extremely difficult. The development of miniature heart-lung machines and further experience in the handling of very small infants will certainly lower the mortality in this group but the child under 10 or 15 pounds remains a serious problem.

Valve Abnormalities

Abnormalities in the valves of the heart constitute another large group of intracardiac defects. Tricuspid atresia or absence of the tricuspid valve is a cause of cyanosis from birth. It is associated with an interatrial septal defect in all patients who survive the first few hours of life. In addition, there is either a ventricular septal defect or a patent ductus to provide circulation to the lungs. Since 1945 the operation of choice for this condition has been a Blalock-Taussig anastomosis to bring the unoxygenated arterial blood into the pulmonary circulation. This operative procedure has the disadvantage that it places an additional workload on the left ventricle which is already overburdened with the shunting of blood from the right atrium to the left side of the heart.

Dr. W. W. L. Glenn[12] has recently introduced an operation which has not had extensive trial but which theoretically avoids the problem of left ventricular strain. It consists of an anastomosis between the superior vena cava and the right pulmonary artery. This procedure has the double-barreled effect of decreasing the volume of blood returning to the heart and also of shunting venous blood directly into the pulmonary artery. Because of the marked underdevelopment of the right ventricle which is associated with tricuspid atresia, no open heart procedures have been employed in this condition.

Pulmonary valvular stenosis and stenosis of the infundibular area of the right ventricle are common abnormalities. The blind methods of transventricular valvulotomy have been largely replaced by open heart techniques employing direct excision of the infundibulum or correction of the valvular stenosis. The major problem in the treatment of patients with pulmonary stenosis is to establish indications for operation. Empirical gradients of blood pressure drop across the valve have been chosen but these constitute inexact criteria for operative intervention.

Stenosis of the aortic valve is probably more serious than pulmonary stenosis because there is a high incidence of serious ventricular arrhythmia and sudden death. A major problem in the treatment of these children is also the establishment of practical criteria for operative intervention. The pressure gradient across a stenotic aortic valve with the child resting in the cardiac catheterization laboratory is quite different from the gradient which is present when the child is actively exercising. Unfortunately, there seems to be little correlation between the electrocardiographic findings and the degree of aortic stenosis.

The operative problems are primarily related to the fact that the coronary artery ostia are adjacent to the aortic valve and a direct approach to the valve necessarily interferes with the coronary circulation. Local cold arrest of the heart by the application of iced saline to the myocardium is currently employed in most cardiovascular centers. There are inherent difficulties associated with this hypothermic myocardium and with reinstitution of cardiac rhythm following arrest. Another problem on the left side of the heart is the presence of residual air within the aorta or left ventricle and the resulting danger of air embolization. This threat can be excluded by meticulous replacement of the air with saline or blood prior to reinstitution of the circulation. The results in the surgical treatment of congenital aortic stenosis have been excellent in contra-distinction to the poor results with calcific aortic stenosis in acquired heart disease.

Combined Defects

Single intracardiac abnormalities occur frequently but it is not uncommon to find a combination of these defects. One of these combinations is pulmonary stenosis with an interatrial septal defect. This condition is a common cause of cyanosis in infancy. The cyanosis is produced by a reversal of blood flow through the atrial defect as the right ventricle fails behind the severe pulmonary stenosis. The blue blood is shunted in a right-to-left direction into the left atrium and into the systemic circulation. Significant cyanosis constitutes an indication for emergency surgery because once the right ventricle fails the pulmonary stenosis must be relieved quickly if the heart is to recover.

The major problem in the handling of these cyanotic infants is establishing the correct diagnosis. The definitive diagnosis can be made by angiocardiography which must be carried out before the child becomes moribund. These desperately ill infants are poor surgical candidates but relief of their pulmonary obstruction is mandatory. A rapid transventricular valvulotomy is the procedure of choice. If successful, this operative procedure yields dramatic results, but the operative mortality remains high.

Transposition of the great vessels is another condition which is commonly associated with several intracardiac abnormalities. In this condition the aorta arises from the right ventricle and the pulmonary artery from the left ventricle. This anatomical relationship is obviously incompatible with extra-uterine life unless there is some intracardiac defect which will allow mixing of the red and blue blood. These intracardiac shunts may be either at the atrial or the ventricular level and occasionally may consist of a patent ductus. The logical direct approach to this problem would be to reverse the major vessels so that they would have their normal ventricular relationships. It has not been possible to carry out this procedure because the coronary arteries cannot be transferred with the aorta.

Dr. Ruth Whittemore and her associates in New Haven have carefully studied a large series of patients with transposition of the great vessels and have found that the best prognosis occurs in those patients with the most effective intracardiac mixing. Specifically, those patients with large interatrial septal defects were found to have the best prognosis. Based upon these findings, the surgical treatment is presently directed toward increasing the intracardiac mixing, primarily by creating or enlarging interatrial septal defects. This has been most successfully accomplished by using general hypothermia, a brief period of inflow venous occlusion, and direct excision of the interatrial septum. Attempts at re-routing the pulmonary venous drainage and the vena cava by transposing these veins have proven to be complicated, with results which are generally unsatisfactory.[13]

The best known combined intracardiac defect is the classical "blue baby" or tetralogy of Fallot. In this abnormality, there are the combined problems of pulmonary stenosis and a ventricular septal defect. Ideally, these two defects should be correctable by open heart surgi-

cal techniques but there remain many problems in achieving this goal. The pulmonary stenosis is often a complex malformation. Not infrequently there is marked hypoplasia of the entire outflow tract of the right ventricle. This necessitates some type of prosthetic reconstruction of the outflow tract which may be an insurmountable technical problem in the infant and small child.

The interventricular septal defect is usually large and within the muscular septum. This is associated with an absence of the membranous septum so that the overriding aortic annulus has no septal support. Closure of this type of defect requires a prosthetic patch which must be sutured below in the immediate area of the conduction bundle and above on the bare annulus of the aortic valve. The combined defects require precise correction and usually a lengthy period of extracorporeal circulation. This prolonged period of cardiac by-pass introduces the factors of increased trauma to the red blood cells and lengthy artificial perfusion of vital organ systems.

In some patients, the pulmonary stenosis is a true agenesis or pulmonary atresia and no correction is feasible. In these patients and in the very small infants no open heart procedures are currently recommended. A systemic to pulmonary artery shunt, as introduced by Blalock and modified by Potts, constitutes the surgical treatment of choice in these cyanotic children. In those patients in whom the anatomical defects can be corrected by open heart techniques, there remains the potential problem of an inadequate distal pulmonary vascular bed.

Most of the deaths which have occurred following satisfactory anatomical repair of the intracardiac defects have been attributed to an immature pulmonary vascular system. Apparently the pulmonary vessels have not developed because of the proximal pulmonary stenosis. Whether these patients would be benefited by a preliminary subclavian-pulmonary artery shunt to allow for a period of pulmonary vascular development remains to be seen but this approach is currently being tried in several medical centers.

If the surgeon or the cardiologist focuses his attention primarily on the difficult problems of the surgical treatment of congenital heart disease, it becomes a very depressing picture. Fortunately, the vast majority of single congenital abnormalities of the heart are relatively uncomplicated and respond beautifully to surgical therapy. The great satisfaction in the field of congenital heart disease lies in this large group of patients in whom the operative procedure results in a normal heart and a child with a life expectancy of more than 50 healthy years.

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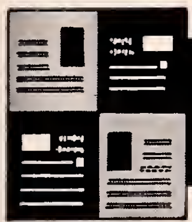
1963 KSMA Interim Meeting Will Be March 7 at Covington

Make Your Plans Now To Attend

(See pages 152-153.)



SPECIAL ARTICLES

A Study of the Kerr-Mills Program in Wolfe County, Ky.

Paul F. Maddox, M.D.

Campton, Ky.

THE KERR-MILLS law has now been in effect for more than one and one-half years and sufficient time has elapsed so that it should now be possible to provide answers to certain questions concerning this law.

Among the questions that should be answered are: Does it serve its purpose in providing adequate medical service for the indigent? Is it abused? Do people seek medical care unnecessarily merely because it is available to them free? Do eligible persons take advantage of its provisions or do they insist upon paying their own way? Is hospitalization more available for indigent patients?

This question should also be answered: Will the provisions of the law and the income it provides encourage practitioners to practice in rural areas with low per capita income? After sufficient time has elapsed perhaps the question can also be answered as to whether or not it will significantly prolong the life of those covered by its provisions.

Eastern Kentucky is an ideal location for implementation of this law, since this is an area in which there are a great number of indigent persons. The average per capita income in most of the mountain counties is a little more than $600 per year and the percentage of people being covered by the various provisions of the Department of Economic Security is quite large in proportion to the total population.

In this particular study, Wolfe County, which is one of the very poorest counties in the State, is used as a basis for the study. In the 1960 Federal census Wolfe County had a population of 6,500 people and out of this population of 6,500 there are 941 on public assistance of which 19 are receiving aid to the needy blind; 67 are receiving APTD; 600, aid to dependent children, and 255 are receiving old age assistance. Therefore, with 941 on public assistance, approximately 14.8% of the population of Wolfe County is eligible for benefits.

The reason that Wolfe County has such a high percentage of persons on public assistance is not because the people are necessarily less inclined to work but because there are absolutely no industries in the county, not even a railroad. Most of the people make a living by tending small farms, particularly raising tobacco. Therefore the better educated and the able-bodied younger generation go to other counties in the State of Kentucky or to other states to find jobs leaving the retired, the widows and the mentally and physically disabled behind. Over a period of years this has resulted in a high percentage of the population consisting of welfare recipients as compared with the rest of the nation.

My own private practice would seem to present an ideal study for the results of the provisions of the Kerr-Mills law. I am the only physician serving this population of 6,500 and have been situated here for almost 10 years. During this 10 years no one has been refused medical care for any reason other than acute behavior problems. We have many people on our accounts who have been treated for 10 years and have never paid a single penny for medical care and have never been refused medical care. Therefore, there was no reason why anyone in Wolfe County, or this region, should be suffering from lack of adequate out-patient medical care for financial reasons.

This care included necessary drugs which were also furnished free of charge to needy persons regardless of ability to pay. My practice, as is characteristic for most of the physicians in Eastern Kentucky, is quite large. During the year the study was made, a total of 29,125 patients were seen during a period of 365 days, and 340 babies were delivered. This makes an average of 79.8 patients per day on a 365-day basis and almost one baby delivered each day. The large patient load is because of the high patient-to-physician ratio in this area.

Fees are quite low, the average charge for an office call being $3 for those who can pay, and a $60 charge for an office delivery, which includes a hospital bed, anesthesia, drugs, room, etc.

Over a period of years, our experience has shown a constant 16.4% loss on all acounts, or in other words, every sixth patient is a charity patient and on charges of $60 for deliveries, we have experienced about a constant 35% loss or about every third delivery pays absolutely nothing. In addition, such persons as the residents of two children's homes located in Wolfe County are treated free and, therefore, do not appear in the above statistics.

How the Study Was Set Up

The study here involves the period of July 1, 1961, to June 30, 1962—one year. The first six months of 1961 has been discarded, since this was the time during which the law was going into effect and was poorly

FIGURE 1

MONTH	Total No. Patients Seen	Total No. Welfare Patients Seen	% of Welfare Patients Seen	No. of Babies Delivered	No. of Mothers on Welfare	No. of Welfare Prescriptions Written
July 1961	2,263	399	17.7	34	1	376
August 1961	2,271	373	16.4	30	4	376
September 1961	2,447	447	19.9	38	2	561
October 1961	2,341	394	16.8	38	0	562
November 1961	1,960	365	19.7	24	0	513
December 1961	2,604	491	18.8	19	0	778
January 1962	2,441	454	18.6	23	3	762
February 1962	2,322	474	20.4	22	0	708
March 1962	2,966	578	19.5	34	1	914
April 1962	2,488	453	18.2	26	1	765
May 1962	2,748	493	17.9	28	1	779
June 1962	2,276	406	17.8	24	2	684
Totals for One Year	29,125	5,327	18.3	340	15	7,778

Prescriptions per welfare patient—1.46

understood by both the patient and the physician. Therefore, the first six months does not represent a true study of the implementation of the law.

As noted in Figure 1, the percentage of welfare patients as compared to total number of patients seen has remained very nearly constant at about 18% over the course of one year. In view of the fact that 14.8% are eligible for the medical care coverage, and in view of the fact that this category of patients are in the age groups such as children and the elderly, which are prone to more illness, it is rather surprising that the percentage of welfare patients seen as compared to total patients is not higher than this figure. It would appear from this that even though the welfare patients are eligible for free medical care, they are not presenting themselves for treatment any more often than would be expected for the normal run of patients.

It can also be noted from Figure 1 that of the 340 babies delivered, only 15 were by mothers who are welfare recipients. Although this series is small, there was no significant increase in the number of pregnancies by these mothers even though they were eligible for partial coverage under the medical care program.

It can be noted under Figure 1 that there have been an average of 1.46 prescriptions per welfare patient seen and also that the number of prescriptions per patient has gradually increased. This, however, is due to the fact that certain patients, such as hypertensives and diabetics, are being maintained indefinitely on medications which may be refilled as needed month after month.

One of the objections to the medical care program is that there are an insufficient number of drugs on the approved drug list and these are of the wrong type. Our experience has been that a great majority of the patients can be treated within the limited drug list and for the $3 office call that we are allowed, we are able to dispense most of the remaining medications such as vitamins, etc., out of our own supply to the indigent patients.

It is a welcome relief to be partially compensated for these medications after nine years of giving them away for nothing. Those patients who are financially able are given prescriptions for such additional medication as they may need but can pay for themselves and no one seems to object to this program.

Some objections have been raised to the delay between the time patients are seen and the time the payment is received from the State Treasurer. We have long been accustomed to waiting all year until tobacco is sold in December and January before receiving compensation for services and also we are accustomed to waiting for the Resurrection for 16.4% of the compensation. Therefore, this short delay by the State Treasurer presents no hardship or objection.

Some objection has been raised to the fact that only 12 visits per year are permitted under the medical care program and for certain chronic patients, it certainly is inadequate. However, our own feeling is that we are grateful that even as many as 12 visits are covered under the program.

Few People Have Applied

A surprising fact concerning the program is that very few people who are eligible under the MAA program have applied for benefits. Of the 775 persons in Wolfe County who are drawing Social Security benefits, mostly in the old age group, only 25 have applied for medical care cards. This means that in one of the smallest, poorest counties in Kentucky, very few of these people are able to pass the means test or have bothered to apply. This certainly brings up certain speculation concerning the need for the King-Anderson type of medical care coverage over which there has been so much controversy.

The Kerr-Mills program has made hospitalization obtainable for those persons needing such care and at this time any welfare recipient patient needing hospital care may obtain this service. During previous years these patients who were critically in need of hospitalization were accepted by Good Samaritan

FIGURE 3

	1957	1958	1959	1960	1961	5 year average	(Six months only) 1962
Per cent of Receipts Collected	86.2	83.0	87.5	83.3	78.1	83.6	91.8
Per cent of Loss	14.8	17.0	12.5	16.7	21.9	16.4	9.2

Hospital in Lexington at a severe economic loss. Wolfe County has no hospital.

Quality of medical care is a difficult thing to measure. In the final analysis the mortality tables are probably the best indicators of quality of medicine. As seen in Figure 2, the death rate in Wolfe County

FIGURE 2

Place	Death Rate 1959	Death Rate 1960	Maternal Death Rate	Death Rate During Study
Kentucky Average	9.6	9.8	.4	Not available
Wolfe County	9.7	11.4	0	9.1
Hardin County (Lowest death rate)	4.5	5.1	0	Not available
Robertson County (Highest death rate)	15.4	15.6	0	Not available
Jefferson County (Most populous)	9.6	9.6	.1	Not available

Statistics from "Statistical Summary for Professional Use." Kentucky State Department of Health 1960. 1961 statistics are not available.

compares favorably with the State average. The decline in the Wolfe County death rate below the previous State average during the year of study may be significant if it persists for several years.

As seen from Figure 3, we have been experiencing a 16.4% loss on all accounts and in an area without hospital facilities where the overhead is very high, this is a vital factor. Payments from the Medical Care Program have increased the collection ratio to 91.8% during the first half of 1962. This could be a vital deciding factor in encouraging young physicians to locate in poor rural areas.

Summary in Conclusion

In this study, there was no evidence that welfare recipients are abusing the Kerr-Mills program or needlessly taking advantage of its provisions.

Although the study is small and brief, there was a definite decline in the crude death rate during the year of study as compared to the previous years which may be significant if the decrease in death rate persists year after year.

The provisions of the law may be instrumental in encouraging young practitioners to come to the poor depressed areas of Eastern Kentucky since during the period of study, collection percentages rose to figures comparable to the national average.

Even in one of the smallest, poorest counties in Kentucky, of 775 persons drawing Social Security benefits, the majority of whom are in the old-age group, only 25 have applied for medical care cards. This would indicate that the great majority of persons in this group are either unable to qualify for benefits or do not need the medical care benefits sufficiently to apply for coverage.

The author concludes that after delivering babies for 25 cents each in this category of patients (I receive 25 cents for filling out a birth certificate), it is certainly a step in the right direction to now receive $3.25 for this service.

March 18

Is the Date for the

Ninth Annual KSMA Senior Day.

at the Medical Arts Building, Louisville

All KSMA Members Invited.

EDITORIALS

Senior Day—March 18

FOLLOWING his years of studying and schooling, it has often been found that one of the greatest challenges to the new M.D. is his transition from a student to a practitioner of medicine. In the early stages of his medical practice, he will run head on into a number of problems which he may not have had an opportunity to study in school because of the crowded curriculum demanded in the technical aspects of his education.

Although this same problem may exist to some extent for the medical graduates from our state, it has been considerably eased by what has now become a tradition—the KSMA Senior Day Program.

Realizing that perhaps one of the greatest assets of the profession is the leaders it cultivates, each year a number of Kentucky physicians take an entire day from their already overcrowded schedule to assist the senior students in this transition from the academic phase of medicine to the actual practice of medicine.

Preparations are now being completed for the presentation of this year's Ninth Annual Senior Day Program sponsored by the Kentucky State Medical Association in cooperation with the University of Louisville Medical School and the Jefferson County Medical Society. The state organization will be seeking to show the soon-to-be-doctor short cuts in starting his medical career that are in the best interest of both the doctor and his patients.

As in past programs, the students will for the first time be exposed to organized medicine and its role in the profession and in society. They will hear a presentation on "Where You Practice" and the activities they are expected to encounter if they practice in an urban area or rural area, and they will learn about the "Human Equation in Medical Practice". Indeed, one of this year's intent listeners will be back for another Senior Day with perhaps the responsibility of informing the students on the "Mechanics of Setting Up A Practice."

Senior Day has proven to be of substantial educational value to the medical student and inspiration to the physician. You, as a member of our state organization, are invited to attend this year's program—next year you could well be a part of it.

Donald Chatham, M.D., Chairman
KSMA Senior Day Committee

Two-Year Medical Schools Will Help Stabilize the Output of Physicians

UPWARD of five per cent of all medical students entering the Freshman class discontinue or are dropped from enrollment before the beginning of the Junior year. This represents a deficit of about 750 annually for whom provision is made in the clinical years—vacancies that remain unfilled—a serious loss in the potential of our medical schools.

A few years ago there were enough graduates of two-year or basic medical science schools to fill this gap and provide a maximum of medical graduates. With the expansion of most of these two-year to four-year schools this source of recruits is lost.

Seven two-year schools have converted to four-year courses since 1940; only three remain, Dartmouth, University of North Dakota, and University of South Dakota. These three with a total enrollment of 202 students cannot nearly supply the vacancies in the Junior classes of the 84 schools granting an M.D. degree. Four additional two-year schools are now being planned—Brandeis, Brown, Michigan State, and the University of New Mexico. These, even at full capacity, cannot make up the deficit of Junior class students.

Applicants from states having no medical school have a particularly hard time finding an opening anywhere in the United States. This is probably worse for students from Hawaii and Alaska. Eleven states are now without medical schools of any sort. If they could provide for their own students the opportunity for two years in basic medical sciences, there would be no lack of openings for them to obtain the M.D. degree from already established schools.

In 1951 when Doctors Anderson and Manlove from the AMA Council on Medical Education surveyed Kentucky concerning the need for expanding our program, they expressed the opinion that the Council did not favor the establishment of two-year schools. At the present time the AMA does favor them but with a number of safeguards that will insure that they will be strong educational institutions.

It would appear that such an approach may be one of the most practical and efficient means of increasing our supply of physicians—and with a more equitable distribution of medical education.

Sam A. Overstreet, M.D.

On Thinking Out Loud

COMPLETE candor and a frank opinion freely expressed are luxuries that a physician may often wisely avoid. At the end of a hard day's work when he is eager to proceed with his hospital rounds or to engage in some form of relaxation which he has planned, the telephone rings just as he is leaving his office or as he opens the door at home. A patient who has been sick for three days insists at this particular time upon immediate service either in the office or at his home. Psychologically he has caught the doctor at a very bad time.

The path of least resistance is to explode. If he does, however, he has made another breach in the "good public relations" about which we hear so much. It is far better for him to decline in firm and friendly words or to acquiesce to the patient's request with as good grace and composure as he is able to muster at the moment. It is an inopportune time to explain in detail the patient's inconsistencies and lack of consideration although he is sorely tempted.

There are occasions when the patient or his family elect to put the physician through a long and unreasonable quiz with regard to the findings or implications of a recent study. They ask questions for which there is no answer and they may require information that is not wise to divulge at the moment. They may ask the same question over and over, phrased differently, and appear to delight in pointing out any inconsistencies in the answers given. It requires patience and tactfulness in the amount that few possess to keep one's equanimity at such times.

The patient is seriously ill. A study of his disease and establishment of a diagnosis has not been completed by the physician and his consultant. The answer to his problem or the outline of suitable treatment has not been formulated when anxious members of the patient's family insist upon a definite statement. It is better to say "I do not know" or that the studies are not yet complete and will require more time, than to attempt to formulate a speculative answer which tomorrow may be proved wrong. Such a course is often difficult to maintain in the face of the patient's insistence, but usually tends to strengthen the confidence of those most deeply concerned.

An inquiry is made with regard to a drug, method of treatment or an institution in which the patient may have an immediate concern. The physician may know at once and without equivocation the answer to the patient's inquiry and he may be tempted to express in very strong language his disapproval of a product or method that is already known to be useless or unsafe. An immediate and emphatic answer, however, may tend only to increase the patient's prejudices and suspicions of the medical profession in general.

The conduct or qualifications of a fellow physician is the subject of discussion and one is asked to express his opinion and advice. We have felt great admiration for some of the older physicians of our acquaintance who under such circumstances have been able to tactfully and courteously avoid any expression of distrust or criticism which might harm a colleague.

We are not required under such circumstances as these to be frank and blunt, to speak the truth, the whole truth and nothing but the truth without fear or favor. Tactfulness and fairness are virtues we would all do well to practice. A poker face and a few innocuous platitudes may be in order. A doctor cannot safely indulge in thinking out loud.

Sam A. Overstreet, M.D.

ORGANIZATION SECTION

1963 KSMA Interim Meeting Program To Feature Top Speakers; Voluntary Insurance, Legislative Problems, Political Action Will Be Topics

An opportunity for a quick but thorough short course from experts on three of the most urgent problems facing the profession of medicine today is offered to those planning to attend the 1963 Interim Meeting of the Kentucky State Medical Association at Covington, March 7.

The program on the succeeding page lists the outstanding speakers and their topics which will cover the physician's role in voluntary health insurance plans; the legislative problems that challenge all physicians today and the ways in which the political voice of the profession may be made more effective.

KSMA President David M. Cox, Louisville, will preside at the morning and luncheon sessions and George P. Archer, M.D., Prestonsburg, president-elect, at the afternoon meeting.

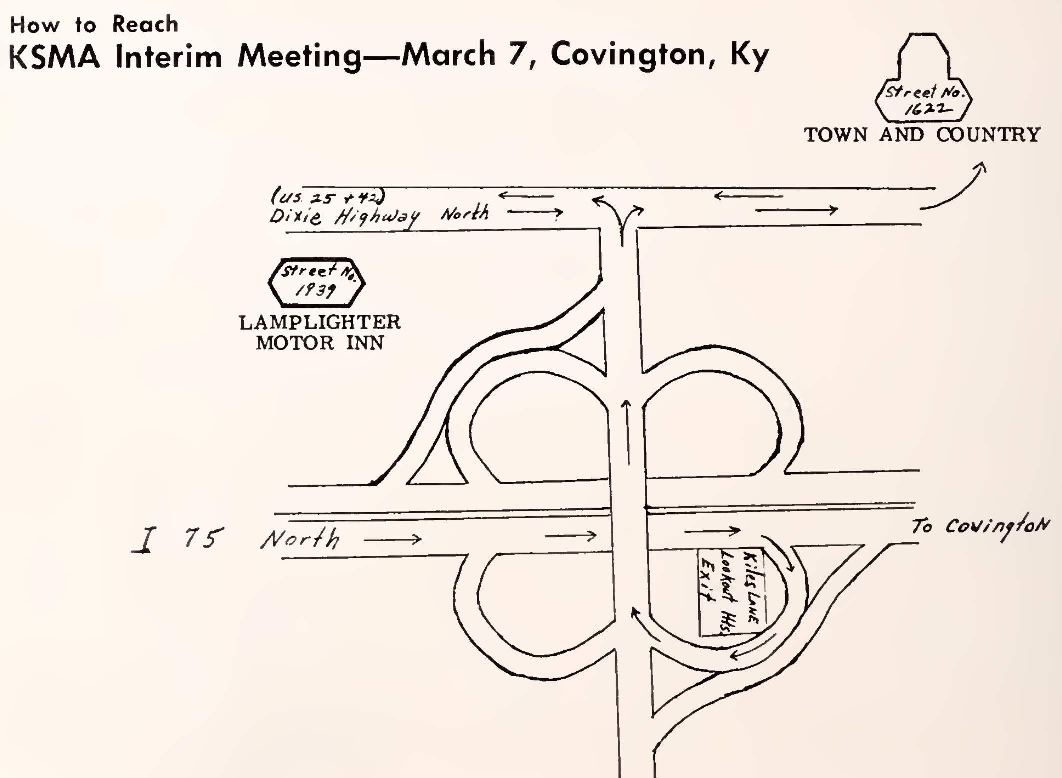
The meeting is being held at the Town and Country Restaurant, Park Hills, Covington, and the map above shows the most convenient way to get to it and to the Lamplighter Motor Inn, where many of the guests plan to stay.

The invocation, opening the morning session of the meeting, will be made by the Reverend Father John Rolf, secretary to the Catholic Bishop of Covington.

Wilbur R. Houston, M.D., Erlanger, president of the Campbell-Kenton County Medical Society, will make the address of welcome and KSMA Secretary Woodford B. Troutman, M.D., Louisville, will make the announcements.

The first guest speaker on the program will be Karl C. Jonas, M.D., chairman of the Physicians Review Board of the Philadelphia Blue Cross, who will

How to Reach
KSMA Interim Meeting—March 7, Covington, Ky



Program

KSMA 1963 Interim Meeting

Town and Country Restaurant, Covington **Thursday, March 7**

MORNING SESSION

David M. Cox, M.D., Louisville, president
Kentucky State Medical Association, presiding

9:00 a.m.*	**Registration**
9:15 a.m.	**Coffee Call**
9:45 a.m.	**Call to Order,** Doctor Cox
	Invocation, the Reverend Father John Rolf, secretary to the Bishop of Covington
	Welcome, Wilbur R. Houston, M.D., Erlanger, president, Campbell-Kenton County Medical Society
	Announcements, Woodford B. Troutman, M.D., Louisville, KSMA secretary
10:00 a.m.	**"The Relation of the Practicing Physician to Voluntary Health Insurance"** Karl C. Jonas, M.D., Philadelphia, chairman of the Physicians Review Board of the Philadelphia Blue Cross
10:30 a.m.	**"Medical Political Problems of the Future"** Ever Curtis, M.D., member, AMA National Speakers Bureau; secretary, Public Relations Committee, Massachusetts Medical Society
11:00 a.m.	**Coffee Break**
11:10 a.m.	**"Continuing Political Effectiveness"** Milton V. Davis, M.D., Dallas, Tex., secretary treasurer of AMPAC
11:40 a.m.	**The Experts Speak** The audience is requested to submit written questions

LUNCHEON SESSION

Doctor Cox presiding

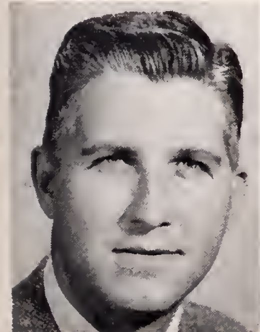
12:30 p.m.	**"PRN (Take As Needed)"** The Reverend Doctor William W. Slider, Louisville, minister of Christ Methodist Church

AFTERNOON SESSION

George P. Archer, M.D., Prestonsburg,
KSMA president-elect, presiding

1:45 p.m.	**"Opportunity vs. Security"** Burl St. Clair, Falls of Rough, Ky., immediate past president of the Kentucky Farm Bureau Federation
2:15 p.m.	**The Experts Speak** The audience is requested to submit written questions
3:00 p.m.	**Adjournment**

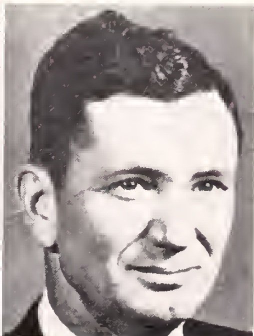
* *All times listed are Eastern Standard time*


Doctor Jonas

Doctor Curtis

Doctor Davis

Doctor Slider


Mr. St. Clair

discuss "The Relation of the Practicing Physician to Voluntary Health Insurance."

"Medical Political Problems of the Future" will be discussed by Ever Curtis, M.D., considered an authority on government and the forces which today are working toward the goal of socialized medicine. Mrs. Curtis is a member of the AMA National Speakers Bureau and secretary of the Public Relations Committee of the Massachusetts Medical Society.

Following a morning coffee break, another outstanding expert in the field, Milton V. Davis, M.D., Dallas, Tex., secretary-treasurer of AMPAC, will speak on "Continuing Political Effectiveness." Doctor Davis played an important role in the instigation and organization of AMPAC, medicine's political action group.

At the close of the morning session, the audience will be invited to submit written questions to the experts.

Addressing the luncheon session will be the Reverend Doctor William W. Slider, minister of Christ Methodist Church, Louisville, who will take as his topic "PRN (Take As Needed)." Doctor Slider is considered to be one of the country's most accomplished speakers and has been active in civic work in Kentucky, Texas and Arkansas.

The immediate past president of the Kentucky Farm Bureau Federation, who served in that office for 10 years—Burl St. Clair, Falls of Rough, Ky., will speak on "Opportunity vs. Security" at the afternoon session. Mr. St. Clair is widely known as a gifted speaker and a vigorous opponent of socialism.

At the close of his address another question period will be held and the meeting will be adjourned at 3 p.m.

New Drug Controls Published; Effective February 7

The new regulations tightening controls over distribution of new drugs for clinical investigation became effective February 7.

According to George P. Larrick, food and drug commissioner, they require, among other things:

That the FDA be notified and given full details about distributions of drugs for investigational use.

That clinical investigations be based on adequate studies on animals to assure safety.

That clinical investigations be properly planned, executed by qualified investigators and that the investigators and the FDA be kept fully informed during the progress of investigations.

The new regulations provide that if such an investigation develops evidence that a drug is not safe or is ineffective, the FDA will require discontinuance. Previously an initial notice to FDA of a clinical trial or subsequent reports on such investigations were not required.

Over 300 written comments were received on the proposed regulations which were published August 10, 1962 and meetings were held with various interested groups.

For further information on the new regulations see Washington News Digest on page 120.

KSMA District Meetings Set For Franklin, Frankfort

Meetings of the Sixth and Seventh Trustee Districts of the Kentucky State Medical Association have been scheduled for February 12 at Franklin and February 21 at Frankfort, respectively.

The Sixth Trustee District meeting at 6:30 p.m. February 12 at the Franklin Country Club will be addressed by Robert W. Lykins, M.D., and Hoyt D. Gardner, M.D., both of Louisville. Doctor Lykins' topic will be: "Legislation and What You Can Do." Doctor Gardner will discuss "KEMPAC and Your Political Freedom." John P. Glenn, M.D., Russellville, is Sixth District trustee.

At the meeting of the Seventh Trustee District at the Holiday Inn, Frankfort, at 6:30 p.m., February 21, KSMA President David M. Cox, M.D., Louisville, will speak on the subject: "You, the KSMA and the Patient." Doctor Gardner will address the group on the topic, "Vote Now and Pay Later." Seventh District Trustee is Donald Chatham, M.D., Shelbyville.

Previous trustee district meetings held were the First on January 24; 13th on February 5, and the Eighth on February 7.

At the meeting of the First Trustee District at Paducah, President Cox and Doctor Gardner spoke. O. Leon Higdon, M.D., Paducah, is First District trustee.

Homer B. Martin, M.D., and Robert C. Long, M.D., both of Louisville, addressed the meeting of the 13th Trustee District at Ashland. Clyde C. Sparks, M.D., Ashland, is 13th District trustee.

On February 7, at the meeting of the Eighth Trustee District at Covington, the speakers were George Sehlinger, M.D., Louisville, and Harold Barton, M.D., Corbin. Eighth district trustee is Dexter Meyer, M.D., Covington.

It was announced at publication time by Thomas O. Meredith, M.D., Harrodsburg, trustee for the 12th District, and by Keith P. Smith, M.D., Corbin, trustee for the 15th District, that these two districts will hold a joint meeting March 28 at Cumberland Falls.

Dr. Crutcher Presents Award

President Frank G. Dickey of the University of Kentucky was presented the distinguished service award of the Kentucky Heart Association January 10 by Richard R. Crutcher, M.D., Lexington, president of the Heart Association. The Award cited Doctor Dickey's "effective and dedicated leadership in the continuing battle against Kentucky's greatest health enemy, the diseases of the heart and blood vessels."

New Orleans Assembly March 4-7

The 26th annual meeting of the New Orleans Graduate Medical Assembly will be held March 4-7 with headquarters at the Roosevelt Hotel. For further information write M.D. Paine, Jr., secretary, 1430 Tulane Ave., New Orleans 12.

Nursing Home Care Now Added to Kerr-Mills Program

With the addition January 1 of nursing-home care to the medical services now available in Kentucky under the Kerr-Mills program, a series of meetings of nursing home operators to acquaint them with the new program, were held January 3 and 4.

Officials of the Kentucky Department of Health met with the nursing home personnel at sessions in Louisville, Lexington, Covington, Glasgow, Owensboro and Paducah.

The new program extends increased payments to about 1,100 Public Assistance recipients now in nursing homes in the Commonwealth and in addition provides nursing-home care payments for the first time to recipients of Medical Assistance for the Aged.

Under the new program all nursing homes in Kentucky are placed in one of three categories and paid accordingly.

In the first are those nursing homes with a medical staff, full-time nurses, hospital affiliation and high quality record and dietary systems. PA and MAA recipients in these homes now will receive full cost for their care for four months; after which payments are reduced to $135 monthly for an indefinite period.

In the second category are nursing homes with only two nurses and a medical-advisory committee. In these payments will be $135 a month.

In the third, the only requirement is that the homes are licensed by the State Health Department and payments will be $115 monthly for PA and MAA recipients.

Recipients in the two top category homes will be allowed to supplement State payments from private sources. Previously any income automatically was deducted from State payments.

By the middle of last month, five nursing homes had applied to the State Health Department for the full-coverage category. Another 28 had applied for the second, and seven for the third or lowest category. Kentucky has 84 licensed nursing homes.

Those applying in the top category were: Geriatrics Center, Waverly Hills; Kentucky Convalescent Home, Owensboro; Friendship House, Inc., Danville; Taylor Manor Nursing Home, Versailles; Carter Moore Nursing Home, Franklin.

A discussion of how Kerr-Mills operates in the State of Kentucky, including preliminary plans for the addition of the nursing home coverage, may be found in the special article by Earle V. Powell, commissioner of the Department of Economic Security, in The Journal for January 1963 on page 50.

West Virginia Academy To Meet

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its 16th annual meeting at the Greenbrier Hotel, White Sulphur Springs, W. Va., April 17-20. For additional information write: Worthy W. McKinney, M.D., Professional Park, Beckley, W. Va.

Program for Heart Symposium March 27-28 Outlined

The Ninth Annual Symposium on Cardiovascular Diseases will be held at the Brown Hotel, Louisville. Ky., March 27-28. The Symposium is sponsored by the Heart Association of Louisville and Jefferson County and the University of Louisville School of Medicine.

Grover B. Sanders, M.D.. Louisville, chairman of the Symposium Committee and instructor in medicine at the U. of L., will preside at the Wednesday morning session.

Speakers and their subjects for the opening session include: Philip Tumulty, M.D., Baltimore, Md., associate professor of medicine, Johns Hopkins University, "Bacterial Endocarditis"; Charles H. Rammelkamp, Jr., M.D., Cleveland, Ohio, professor and director of medicine, Cleveland Metropolitan General Hospital and Western Reserve University School of Medicine, "Rheumatic Fever"; C. Thorpe Ray, M.D., Columbia, Mo., professor and chairman, Department of Medicine, University of Missouri, "Myocarditis."

A panel discussion, moderated by Kenneth P. Crawford, M.D., Louisville, assistant professor of pediatrics and child health, U. of L., will follow. The subject: "Rheumatic Fever."

Walter S. Coe, M.D., Louisville, associate professor of medicine, U. of L. and president of the Heart Association of Louisville and Jefferson County, will preside at the Wednesday afternoon session.

Following film presentations, the following will speak on the subject of "Anticoagulants": Oglesby Paul, M.D., Chicago, past president of the American Heart Association and professor of medicine at Northwestern University; Victor Gurewich, M.D., Boston, instructor in medicine, Harvard University Medical School, and James V. Warren, M.D., Columbus, Ohio, president of the American Heart Association and professor and chairman of the Department of Medicine, Ohio State University.

A panel discussion will close the afternoon session. Subject: "Anticoagulants"; moderator, Doctor Coe.

Doctor Paul will be the dinner speaker Wednesday evening.

Presiding at the Thursday morning session will be Beverly T. Towery, M.D., Louisville, professor and chairman, Department of Medicine, U. of L. Speakers and their subjects will be, as follows: David Littman, M.D., West Roxbury, Mass., assistant clinical professor of medicine, Harvard, and chief, cardiology service, V. A. Hospital, West Roxbury, "The Use of X-Ray in the Identification and Evaluation of Coronary Heart Disease"; Ernest W. Reynolds, M.D., Ann Arbor, Mich., associate professor, Heart Station, University of Michigan, "The Future Directions of Electrocardiographic Interpretation"; Benjamin Felson, M.D., Cincinnati, professor and director of radiology, University of Cincinnati, "Some Fundamentals of Cardiac Roentgenology."

A clinical pathological conference will follow, moderated by Ivan Bennett, M.D., Baltimore, professor and director, Department of Pathology, Johns Hopkins. Participating will be Doctors Littman, Felson and Towery and Morris M. Weiss, Jr., Louisville.

Richard R. Crutcher, M.D., Lexington, president of the Kentucky Heart Association, will preside over the Thursday afternoon session. After a showing of films, the following will speak:

George C. Morris, Jr., M.D., Houston, Texas, assistant professor of surgery, Baylor University, "Intestinal Angina"; John H. Laragh, M.D., New York City, associate professor of clinical medicine, Columbia University College of Physicians and Surgeons, "Aldosterone Secretion in Man and Its Relation to Hypertension and Heart Failure"; George H. A. Clowes, Jr., M.D., Charleston, S. C., professor and chairman of the Department of Surgery, Medical College of South Carolina, "The Relationship of Cardiovascular and Pulmonary Function to Recovery Following Cardiac Surgery."

The final feature of the program will be a "What's Your Question?" panel discussion presided over by John S. Llewellyn, M.D., Louisville, U. of L. instructor in medicine.

Medical Economics Seminar

"Medical Economics" was the subject of the four-session fall seminar of the Jefferson County Chapter of the American Academy of General Practice held in October at the Kentucky Baptist Hospital, Louisville.

Topics considered were, "Business Side of Medicine," "Tax Gimmicks," "Estate Planning and Trusts," and "Savings and Investments."

Speaks in Denver

Carroll L. Witten, M.D., Louisville, speaker of the congress of delegates of the American Academy of General Practice, spoke at the University of Colorado School of Medicine January 16. He discussed postgraduate education for the general practitioner.

Cornell Auto Injury Study Moves To New Kentucky Areas Feb. 1

"Phase Two" of the Kentucky-Cornell Automotive Crash Injury Research study began February 1 in two new areas in the Commonwealth.

Included in this period, which will run until July 31, 1963, are the following counties: Allen, Barren, Boyd, Butler, Carter, Edmonson, Greenup, Hart, Lawrence, Logan, Simpson, Warren. Elliott County, while not officially active, is included in this phase due to the possibility of having fringe area hospitals.

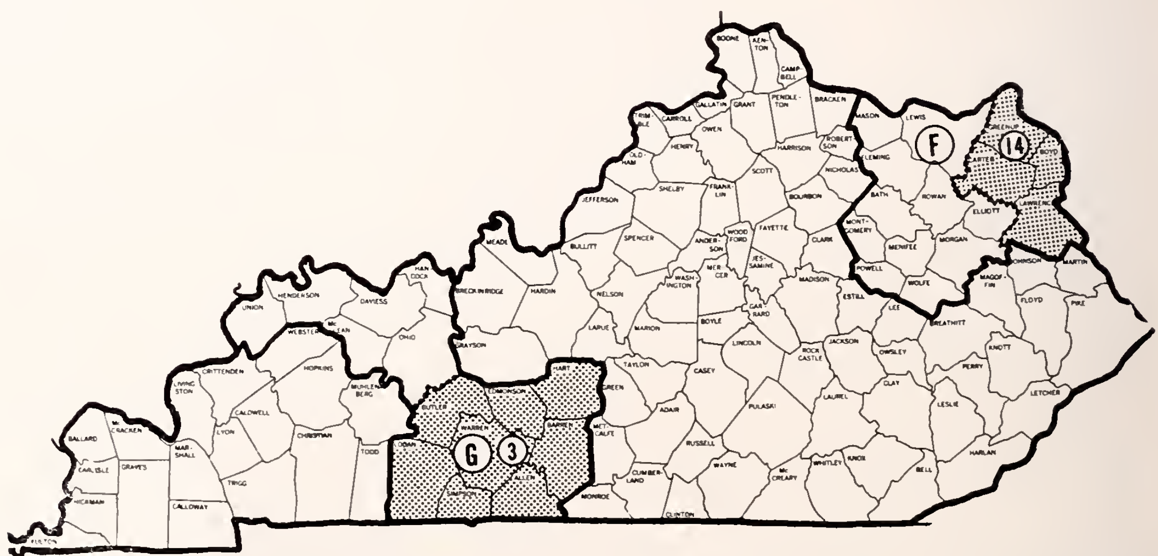
During this period of the study, physicians of these counties are being asked to submit medical reports giving specific information on the extent and nature of injuries to traffic accident victims. The program is sponsored by Cornell University's Automotive Crash Injury Research in cooperation with the Kentucky State Police, Kentucky Department of Health, Kentucky Hospital Association and is approved and endorsed by the Committee on Highway Safety and the Executive Committee of the Kentucky State Medical Association.

The first phase of the study was conducted in the following counties: Anderson, Bell, Fayette, Franklin, Knox, Harlan, Scott, Shelby, Spencer and Woodford.

In this connection, Cornell representatives conducting the study said:

"The response and interest of all persons involved is most gratifying. On the basis of this initial sampling period, it can be said that no state in the Interstate ACIR program ranks higher than Kentucky in terms of producing valid, reliable, well-documented cases which are so important not only for statistical analysis but for clinical study to enable automotive engineers to effect further design modifications aimed at reducing needless and excessive injuries."

Additional information on the study was contained in a special article in The Journal for August 1962, page 775.



Injuries sustained in accidents in the shaded areas involving passenger cars and investigated by the Kentucky State Police are being reported for the Cornell Automotive Crash Injury Research project's second sampling period which began February 1 and ends July 31.

Ninth Annual KSMA Senior Day Planned for March 18

Jim Comstock, widely-known humorist, will be featured speaker at the evening session of the ninth annual KSMA Senior Day, scheduled for March 18 at Louisville. Mr. Comstock is editor of the West Virginia Hillbilly at Richwood, W. Va., and will speak following the social hour and dinner.

As in the past, at the evening session of the 1963 Senior Day University of Louisville senior medical students will be the individual guests of members of the Jefferson County Medical Society. The Kentucky State Medical Association sponsors Senior Day in cooperation with the University of Louisville and the Jefferson County Medical Society.

Sessions will get underway at noon in the Rankin Amphitheatre at General Hospital. The afternoon session will be held at the Medical Arts Building as will the evening meeting. During the afternoon, subjects of interest to the graduates—such as "Bridging the Gap," "Human Equations in Medical Practice," "Economics of Medicine," etc., will be discussed.

Donald Chatham, M.D., Shelbyville, is chairman of the KSMA Senior Day Committee, and Samuel R. Scheen, Jr., M.D., Louisville is Jefferson County chairman. (See Editorial on page 150.)

Pictured at the operating table at a demonstration of the Emergency Training Hospital in Bardstown on December 12, 1962, are, left to right: John J. Sonne, M.D.; Mrs. Elaine Allgier, nurse; Mrs. Maxine Keene, nurse; William H. Keeling, M.D.; and Kenneth L. Stinnette, M.D.—all of Bardstown. (See story on this page.)

Emergency Hospital Set Up at Bardstown

It was a cold calm morning at 8 a.m. in Bardstown, Ky., on Wednesday, December 12, 1962. Two hours later, a functioning hospital had been set up in the National Guard Armory by volunteers, most of whom had never before taken part in such an activity.

A coordinated effort of these volunteers in cooperation with the Nelson County Medical Society, Kentucky State Medical Association, Kentucky State Department of Health, and the U.S. Public Health Service had received and put into operation one of the 28 emergency hospitals stored in various sections of our State.

When our representative arrived on the scene, he found everything in "go condition" and all stations manned. In this short period of time, equipment was unloaded, uncrated, assembled, and, standing ready in their assigned area, were personnel in admitting, triage, shock, ward, morgue, x-ray, central supply, operating, and the pharmacy.

Two "casualties," made up in such a way that realism was easy to comprehend, were admitted and immediately examined in the triage area. One was takent to x-ray, where Polaroid film made development possible in one minute, and then quickly to surgery. (See picture on this page).

It wasn't just play for the 70 medical and paramedical personnel of Nelson County for they have learned the mechanics of setting up an emergency hospital by doing it themselves.

John J. Sonne, M.D., president of the Nelson County Medical Society, said "This has been very beneficial to our people. By doing the job themselves, they won't soon forget how it was done." Doctor Sonne felt that this practical experience was time well spent.

In the event of nuclear attack on our country, many of our permanent hospitals will be destroyed. These emergency hospitals will then be major facilities. It is anticipated that we will ultimately have over 10,000 of these hospitals in the country.

If you are interested in having a demonstration of the Emergency Hospital conducted in your county, write to:

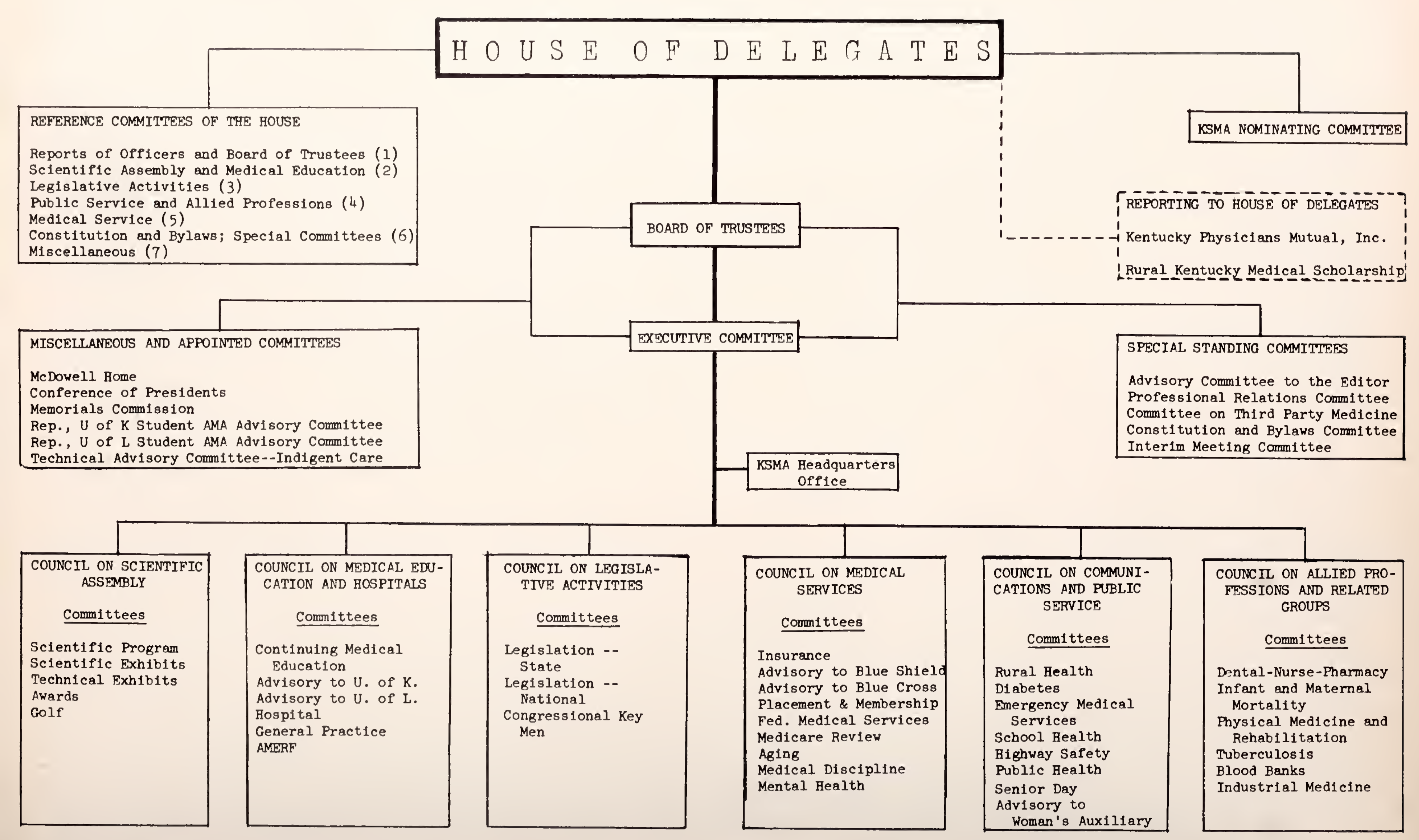
William T. Rumage, Jr., M.D., Chairman
Emergency Medical Services Committee
Kentucky State Medical Association
3532 Janet Avenue
Louisville 5, Ky.

Governor Names Physicians

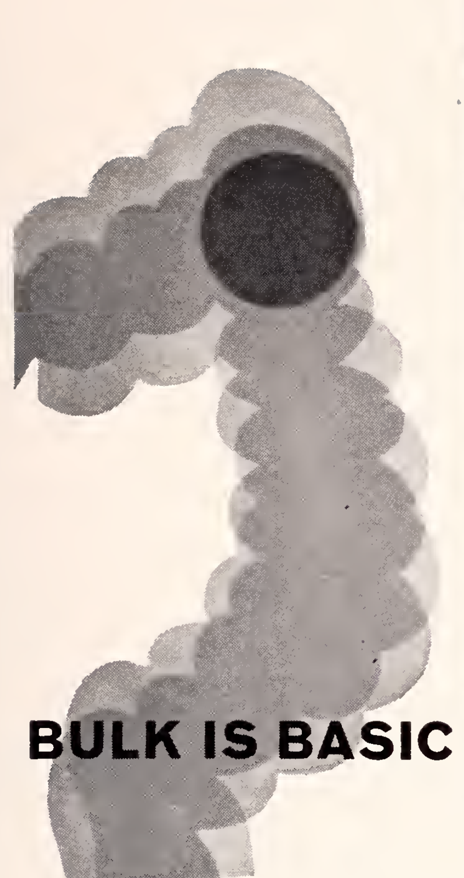
R. Ward Bushart, M.D., Fulton; H. B. Murray, M.D., West Liberty, and Ralph J. Angelucci, M.D., Lexington, along with Gilbert Kingsbury of South Fort Mitchell are the four University of Kentucky trustees named by Governor Bert Combs to join four U. of K. faculty members to screen candidates for president of the University to succeed Frank G. Dickey of the U. of K. who has resigned to take another educational position.

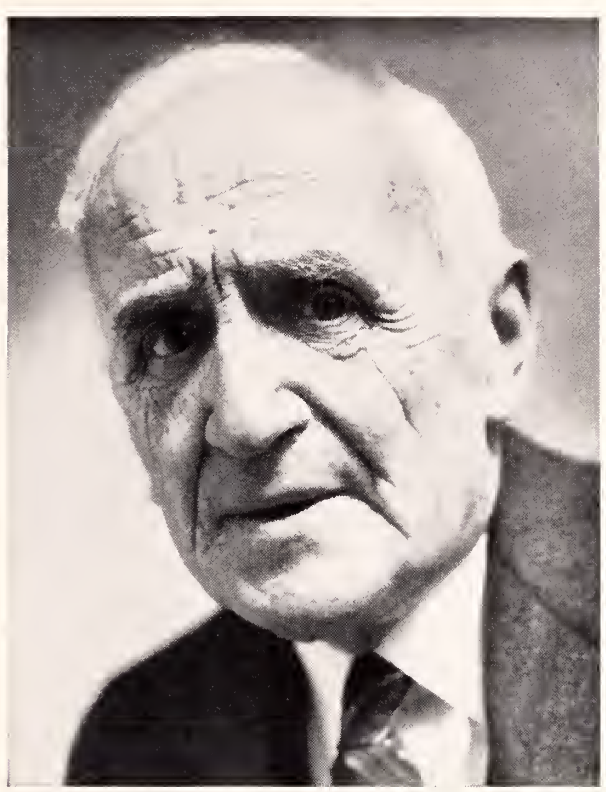
KAGP To Meet May 8-10

The annual meeting of the Kentucky Academy of General Practice will be held at the Kentucky Hotel, Louisville, May 8-10. The Journal expects to carry the full program in the March issue.



KSMA Organization Chart Revised as of January 1, 1963





BULK IS BASIC in geriatric constipation

METAMUCIL®

adds tone to the atonic colon

Metamucil, refined hydrophilic mucilloid, is especially suited to correct the kind of constipation most frequently encountered in elderly patients.

Metamucil adds soft bulk to the often inadequate diets of older persons and supplies the gentle intracolonic pressure needed to induce normal peristaltic action.

This true physiologic stimulus increases muscle tone, encourages normal reflex activity and helps reestablish the natural rhythmic function of the bowel. Only a soft bulk stimulus like Metamucil offers such natural encouragement to normal evacuation.

Metamucil is available as Metamucil powder in 4, 8 and 16 oz. containers and as lemon-flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

METAMUCIL®
brand of psyllium hydrophilic mucilloid

G. D. SEARLE & CO.
CHICAGO 80, ILLINOIS
Research in the Service of Medicine

BENEFICIAL RESULTS were obtained with **SARDO** in the bath in 122 of 135 patients (90%) with dry, itchy skin conditions, in most cases with beneficial effect "after the first bath." Dryness was allayed in all cases, and associated itching "either completely relieved or greatly improved." No irritation or sensitization was observed.

This new study corroborated others[2-4] showing that SARDO helps re-establish the normal physiologic lipid-aqueous skin balance.

Pleasant, easy-to-use SARDO releases millions of microfine water-dispersible globules* in the bath. Bottles of 4, 8 and 16 oz.

* Patent Pending T.M. © 1963 by Sardeau, Inc.

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2. Spoor, H. J.: N.Y. State J.M. 58:3292, 1958.
3. Lubowe, I. I.: Western Med. 1:45, 1960.
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Barton McSwain, M.D., To Speak At Ky. Surgeons Meeting

Barton McSwain, M.D., Vanderbilt University, Nashville, Tenn., will make two addresses during the annual meeting of the Kentucky Chapter of the American College of Surgeons at the Brown Hotel, Louisville, March 29-30.

At the Friday afternoon session his topic will be: "Carcinoma, Colon, Rectum and Anus," and Saturday morning he will speak on: "The Rise and Possible Decline of Surgery."

Following Doctor McSwain's address Friday afternoon there will be a panel discussion on the subject, "Intensive Patient Care," which is intended primarily for hospital administrators. Moderator of the panel will be William T. Rumage, Jr., M.D., Louisville.

During the meeting James H. Spencer, M.D., a representative of the American College of Surgeons, will be present.

The Department of Surgery of the University of Louisville will have charge of the Friday morning program.

Henry Johnson, Ph.D., D.D., Fort Worth, Tex., will be the speaker for the Friday evening dinner session and will have as his subject, "How To Be Happy—Although Married."

Clyde C. Sparks, M.D., Ashland, is president of the Kentucky Chapter and Laurence M. Quill, M.D., Newport is secretary-treasurer. Delmas M. Clardy, M.D., Hopkinsville, is program chairman for the annual meeting and David Kinnaird, M.D., Louisville, is chairman of the arrangements committee.

Blue Shield Payments High

Approximately $706,000,000—an all-time high for such a period—was paid out by the 74 Blue Shield Plans of the United States and Canada for care rendered to members during the first nine months of 1962. Figures announced by the National Association of Blue Shield Plans January 17 also revealed that in the same period more than 1,078,500 enrolled to bring membership to 50,200,787 as of September 30, 1962.

One out of every four Americans and 16% of Canadians are now enrolled in a Blue Shield plan, the Association said. The report also indicated that during the nine-month period payments to policyholders represented approximately 90% of total income with less than 9% going for administrative expenses.

This is the new Medical-Dental Research Building in the University of Louisville Medical Center, which will be dedicated April 6-7. A scientific session will be held April 6. The formal dedication ceremony will be April 7 at 3 p.m. Departments of the School have already moved into the new structure. The seven floors of the building are occupied as follows: Basement: audio-visual; first, obstetrics-gynecology, pediatrics, dentistry; second, pathology, dentistry; third, surgery; fourth, pharmacology; fifth, physiology; sixth, medicine, and seventh, surgery.

U. of L. Library Committee Urges Continuing Fund Support

An appeal to physicians urging continued support of the Friends of the Medical Library Fund for the University of Louisville School of Medicine has been sent to physicians in the State by the Library Committee, headed by Eugene H. Conner, M.D., Louisville.

The Committee pointed out that preliminary plans for a new medical sciences library in the Medical Center are complete and will be executed with development of the new medical school complex. During the past year, the letter states, two new positions have been established: An assistant librarian for public services (reference and bibliographic searching), and one for technical services (cataloguing and purchasing). At present, it reports, the Library stacks contain over 55,000 volumes; nearly 1,000 medical and scientific journals are subscribed to, and photocopying equipment and microfilm and microcard readers and printers are available.

In 1962, the letter continues, the Friends of the Medical Library contributed more than $2,000 to the fund which made it possible to pay salaries of student assistants and keep the Library open in the evenings. Continuing contributions to the Fund are sought by the Committee.

May 2-4 Conference Scheduled on Health Care of Aged

The Third National Conference of the Joint Council to Improve the Health Care of the Aged will be held at the Fairmont Hotel in San Francisco May 2-4, 1963.

This Conference is of special importance at this time because of the announced intention of the present Administration to make an all-out drive during the current session of Congress to include the financing of medical care for the aging under Social Security.

Medicine in particular is being called on to demonstrate initiative and leadership in meeting the health needs of older people. Adequate programs of medical care are now available to all those who need them. It is imperative that all voluntary organizations work together to assure the public of this fact, said Frank Gaines, M.D., Louisville, Chairman of the KSMA Committee on Mental Health.

Anesthesiologists Elect

William N. Nash, M.D., Louisville, was elected president of the Kentucky Society of Anesthesiologists January 20 at the Society's annual meeting at Louisville. Other new officers are: Chester B. Theiss, M.D., president-elect; Jack Wilhoit, M.D., vice president, and William Hopkins, M.D., secretary-treasurer —all of Louisville.

KHA Meeting To Be April 1-4

The Kentucky Hospital Association will hold its 1963 annual convention at the Kentucky Hotel, Louisville, April 1-4.

KSMA Annual Meeting To Feature Color TV Presentation

Demonstrations and presentations via color television will be an outstanding feature of the 1963 Annual Meeting of the Kentucky State Medical Association at Lexington, September 24-26.

Programs will be televised in color originating in the University of Kentucky Medical Center for presentation to those attending the meeting in the Crystal Ballroom of the Phonix Hotel.

Color television chairman for the Annual Meeting is J. Alex Haller, Jr., M.D., Louisville; co-chairman is Harold D. Rosenbaum, M.D., Lexington.

The KSMA Annual Meeting will be one of 16 medical meetings in 1963 at which Smith Kline & French color television will be featured. The only other state association meetings at which such broadcasts will be featured are the Indiana State Medical Association October 15-17 and the Michigan Clinical Institute, March 13-15.

In 1962, 40,000 physicians and surgeons at 14 medical meetings viewed color television programs with the aid of Smith Kline & French.

Opportunity for Physician To Aid Doctor Seagrave in Burma

There is an urgent need for a young well-trained American physician to work with the renowned Gordon S. Seagrave, M.D., at his hospital at Namkham, Burma, according to the 40th Anniversary Committee Honoring Gordon S. Seagrave, M.D., and the American Medical Center for Burma, Inc. David McKendree Key is chairman of the National Committee. Sponsors include many prominent Americans and Burmese.

The following letter points up the need and the opportunity:

To the Editor:

An excellent opportunity exists for a young American general practitioner with an interest in surgery, to work with the famed, Burma surgeon, Gordon S. Seagrave, M.D., at his 250-bed hospital in Namkham, Burma.

Minimum appointment is for two years. With satisfaction an extended tenure would be encouraged.

The candidate should be an American citizen of any race or religion but his age should not exceed 40. He may be married or single. If married to a trained nurse, there would be an important place for her in the nurses training program; or to a school teacher, an opportunity to teach in the secondary school on the hospital compound.

Extensive experience is not a requirement but graduation from an "A" class medical school is. Professional practice at the Namkham Hospital is intensive, widely varied and often rare to Western medical experience.

The candidate must be prepared to leave for Burma not later than the Spring of 1963, or sooner if possible (depending upon issuance of his visa) so that his appointment can overlap that of the American doctor now serving the program.

This appointment offers a modest salary per an-

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num. Travel expenses and Western style housing will be provided.

Anyone interested should please write: American Medical Center for Burma, Inc., 6 Penn Center Plaza, Philadelphia 3, Penn., stating qualifications, etc.

John F. Rich
Executive Vice Chairman

County Society Reports

McCracken

B. A. Washburn, M.D., was elected president of the McCracken County Medical Society for 1963 at the December 19 meeting of the Society. Other new officers are as follows:

O. D. Maxey, M.D., vice president; V. D. Pettit, M.D., secretary-treasurer. Rex Holland, M.D., and W. M. Turner, M.D., were elected to the executive committee. W. B. Haley, M.D., was named to the board of censors. R. M. Wooldridge, M.D., was named delegate to the KSMA; G. W. Widener, M.D., and W. E. Sloan, M.D., are the other two delegates. Charles Billington, M.D., and D. D. O'Sullivan, M.D., were named alternate delegates. O. Leon Higdon, M.D., is also an alternate delegate.

Doctor Wooldridge, together with N. A. Parrott, M.D., and W. D. Shidal, M.D., were named public health department representatives.

A committee for mass polio immunization, headed by Doctor Holland, was reappointed. It had been dissolved in October.

Speaker at the meeting was Nicholas Pisacano, M.D., University of Kentucky Medical Center, Lexington. He discussed continuing medical education.

Edward L. Burns, M.D., Toledo, Ohio, pathologist, was the featured speaker at the November meeting of the Society on, "Cytology in Cancer Diagnosis."

Campbell-Kenton

Wilbur R. Houston, M.D., Erlanger, is the new president of the Campbell-Kenton County Medical Society. Other new officers are: Donald K. Dudderar, M.D., Newport, president-elect; Paul Klingenberg, M.D., Covington, secretary-treasurer.

David M. Cox, M.D., Louisville, president of the Kentucky State Medical Association, addressed the meeting December 6 at which the new officers were installed.

Mercer

New officers of the Mercer County Medical Society are as follows: President, Thomas C. VanArsdall, M.D.; vice president, Ralph T. Ballard, M.D., and secretary-treasurer, C. B. VanArsdall, Jr., M.D. All are of Harrodsburg.

The new president will serve as delegate to the KSMA with John Baughman, M.D., retiring president, as alternate. Censors named are: George Ballard, M.D.; James Keightley, M.D., and Doctor Baughman.

Pike

New officers of the Pike County Medical Society are, as follows: President, G. N. Combs, M.D., Pikeville; vice president, Elvis Thompson, M.D., Stone, and secretary, O. W. Thompson, M.D., Pikeville.

MEDICAL SCHOOL NEWS

U. of L. Names Doctor Anderson; Other Appointments Made

William H. Anderson, M.D., Harlan, has been named to head the new center for pulmonary disease scheduled to open next June at the University of Louisville School of Medicine.

J. Murray Kinsman, M.D., dean of the School, announced the appointment. Doctor Anderson was named associate professor of medicine and associate in physiology on January 16.

At present Doctor Anderson is director of the cardio-pulmonary laboratory at Harlan Memorial Hospital. He was graduated from the University of Chicago Medical School in 1949; served three years' residency in internal medicine and another year in chest diseases at U. S. Public Health hospitals on Staten Island and in Brooklyn, N.Y.

Establishment of the new pulmonary disease center was made possible by a grant which over a five-year period will total $22,500 from the Kentucky Tuberculosis Association, local TB associations and the American Thoracic Society. Initially the center will be located in Louisville General Hospital.

Half of the grant will come from TB Christmas Seal funds as a memorial to the late L. E. Smith, M.D., who was executive secretary of the Kentucky Tuberculosis Association for 20 years. The rest is from the American Thoracic Society. The University will supplement the grant.

Doctor Dennis Resigns

Warren H. Dennis, Ph.D., director of ophthalmic research at the U. of L., has resigned to take a position with the University of Wisconsin at Madison to develop a new bio-medical-engineering program. He has been with the U. of L. since 1956.

On December 19, the U. of L. Board of Trustees approved the following appointments: D. Geraldine Paxton, M.D., and Carmine James Scalzitti, M.D., to be instructors in pediatrics; Ahmad Hatam, M.D., instructor in radiology; Stanley William Collis, M.D., instructor in orthopedics.

John F. Ice, M.D., assistant professor of psychiatry, was named also associate in pediatrics.

On January 16 Giovanni Raccuglia, M.D., was named associate professor of medicine and chief of the section on hematology; Marie M. Keeling, M.D., was named instructor in medicine.

Dwight C. Townes, M.D., professor of ophthalmology and chief of the ophthalmology section which recently became a department, has been named chairman of the Department.

Doctor Levy Receives Grant

The sum of $56,000 in federal grants has been received by Robert S. Levy, Ph.D., assistant professor of biochemistry at U. of L. School of Medicine, to continue basic research on coronary artery disease. The grants from the National Science Foundation and the National Institutes of Health were announced by

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the University January 15. Doctor Levy will also receive a continuing $10,500 annual grant from the American Heart Association.

Other grants and gifts received by the U. of L. School of Medicine recently include: $16,000 from the National Science Foundation to renovate the old Reynold Metals Company building space for laboratories for basic research and training in ophthalmology; $14,000 from the National Science Foundation for support of a program to train superior undergraduates in research in biochemistry under the direction of Calvin Lang, M.D.

U. of K. Announces Schedule For Surgery Days

The schedule for future surgery days at the University of Kentucky is as follows: February 21, Gastrointestinal Surgery; March 21, Endocrine Surgery; April 18, Cancer Surgery; May 16, Surgical Physiology.

The name of the Department of Physiology has been changed to Department of Physiology and Biophysics.

On January 7, eight bassinets in the premature infant nursery were activated. When full capacity is reached, 20 will be available, four each in five rooms, and 15 incubators will be available. The Bureau of Maternal and Child Health of the State Health Department is helping to sponsor the development of the nursery which will be under the direction of John J. Boehm, M.D., instructor in pediatrics.

Rudolph J. Muelling, Jr., M.D., director of the Division of Legal Medicine and Toxicology in the Department of Pathology, has been named an honorary consul to the Republic of Costa Rica for the State of Kentucky.

In the 1962 annual report of the W. K. Kellogg Foundation, mention is made of a $15,000 appropriation to the U. of K. College of Medicine to establish a loan fund for undergraduate medical students.

Doctor Gaines Renamed To Board

Frank M. Gaines, M.D., Louisville, has been reappointed to the Kentucky State Board of Personnel for a four-year term ending January 1, 1967. The appointment was made by Governor Bert T. Combs.

Musical Society Planned

A group of Philadelphia physicians is interested in forming a Doctors' Musical Society to perform classical symphonic, chamber and choral music and which will be open to physicians and their immediate families. Eugene Ormandy, director of the Philadelphia Orchestra is a consultant to the Society. Additional information may be obtained from the Society, c/o Department of Pediatrics, 1025 Walnut St., Philadelphia 7.

A nine-month tutorial program in Cardiology—September 15, 1963 to June 15, 1964—will be offered by the Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, LaJolla, Calif. For details write the Executive Secretary of the Institute.

KSMA Council, Committee Reports

Council on Medical Education and Hospitals

Walter S. Coe, M.D., Chairman

Louisville **December 6, 1962**

The Council on Medical Education and Hospitals met December 6, 1962, in the KSMA Headquarters Office Building.

During this meeting, the chairmen of the committees under the Council gave their initial reports and discussed their committees' plans for the 1962-63 associational year.

Another important action taken by the Council was to accept the recommendation of the Postgraduate Medical Education Committee that a new secretary be employed by KSMA, that a portion of this secretary's duties be to maintain the Postgraduate Program throughout the State, and that a portion of her salary be paid from the Postgraduate Medical Education Fund.

The meeting was adjourned following an excellent report by William R. Willard, M.D., on the AMA Clinical Meeting held in Los Angeles during November.

Council on Medical Services

Claude C. Waldrop, M.D., Chairman

Louisville **December 20, 1962**

The Council on Medical Services met in the KSMA Headquarters Office on December 20, 1962, and heard the reports and recommendations of its various committees. It was noted that the Headquarters Office had already filled some 200 requests with over 15,000 copies of the newly adopted Health Insurance Council "short form" insurance claim form.

The Mental Health Committee's recommendation that KSMA endorse the AMA-approved program for Mental Health, that this be brought to the attention of the KSMA membership, and that KSMA assist in the long-range planning of the program of the Kentucky Department of Mental Health was approved and recommended to the Board of Trustees.

On a matter concerning the changing of the Medical Practice Act, the Council recommended that the Mental Health Committee pursue this subject to its logical conclusion.

A presentation on the new Keogh Law was presented and action to adopt any particular proposal was deferred until a later date.

The Council voiced its approval of the Board of Trustees' recommendation that the matter of an annual registration of physicians be referred to the House of Delegates.

School Health Committee

R. E. Davis, M.D., Chairman

Lexington **December 27, 1962**

The School Health Committee held its first meeting for this associational year at the Campbell House in Lexington, December 27, 1962. Upon being informed that the Committee's resolution on Physical Education had been approved by the KSMA House of Delegates, the members of the Committee requested that

a copy of this resolution be sent to the State Superintendent of Public Instruction.

The Chairman reported on the School Health Committee exhibit and the Panel on Athletic Injuries, both of which were presented at the 1962 Annual Meeting. An annual review of physicians interested in athletic medicine was initiated for the purpose of placing them on a mailing list for a special newsletter.

The Committee reviewed a report of the 1962 Athletic Injury Prevention Conferences and deferred any action toward future conferences until its next meeting scheduled for April 4, 1963.

McDowell Home Committee

Francis M. Massie, M.D., Chairman

Danville **December 15, 1962**

The Old Crow Inn in Danville was the site of the McDowell Home Committee meeting on December 15, 1962.

Highlighting this meeting was an announcement that the McDowell Library and two handwritten letters had been donated to the McDowell Home. One of the letters, dated January 8, 1815, was written by Doctor McDowell to his brother-in-law. The other, dated October 20, 1835, was written by Doctor McDowell's wife. The letters were given by William C. Scott, New York, in memory of his mother, Mrs. Catherine Shelby Scott, a great granddaughter of Doctor McDowell.

The Ephraim McDowell Library is being given by Otto C. Brantigan, M.D., Baltimore, Md. Doctor Brantigan came into possession of the library through a patient of his, a Reverend Mr. Parsons, one of Doctor McDowell's descendants.

The Committee hopes to fireproof at least some part of the McDowell Home to house the library.

Student AMA

New Curriculum at U. of L. School of Medicine

The month of January brought the announcement of a new and unique curriculum at the University of Louisville, a curriculum which will attract more students and one which will undoubtedly produce doctors with a more thorough and basic understanding of the principles of medicine. The students at the U. of L. Medical School feel that this is a much needed and long awaited change, but at the same time realize that changes of such importance and magnitude do not evolve overnight.

The Freshman Class of 1963-1964 will find 25% of the previous classroom time to be used for electives, both at the Medical Center and on the U. of L. campus. These electives will be chosen by the student, with the aid of an advisor, according to the student's own interest and past record. This field of interest will be pursued for three years and climaxed with a research problem in the Senior year. This research problem will be designed by the student on the basis of his preceding elective work thus stimulating creative thinking.

The "core curriculum" or the other 75% of the class time will be composed of correlated basic courses, with time spent observing or working with patients. For example, while studying the circulatory system in Physiology, the student will be taught O_2 uptake and acid-base balance in Biochemistry, the origin and development of the red blood cell in Histology and will observe patients with circulatory disturbances in the clinics.

Other changes in the curriculum are needed and are forthcoming; but suffice it to say now, the Curriculum Committee has taken a definite step toward modern medical education. Only time will bear out the foresight of those individuals responsible for this change. We are confident that this new curriculum will reap its benefits.

Jerry B. Buchanan, President
U. of L. Chapter, SAMA

John E. Myers, Jr., M.D., has opened an office at Lexington for the practice of internal medicine and gastroenterology. Doctor Myers was graduated in 1954 from the University of Louisville School of Medicine. He interned at Fitzsimons Army Hospital, Denver, and took residency training at Walter Reed Army Hospital, Washington, D. C. Doctor Meyers served in the U. S. Army Medical Corps for eight years with the rank of major.

H. W. Reckmann, M.D., is now serving as radiologist with the Adair Memorial Hospital, Columbia, Ky. A native of Freiburg, Germany, Doctor Reckmann attended the Munich University Medical School and interned at the American Hospital, Chicago. He took his residency training at Bellevue Medical Center and Francis Delafield Hospital in New York and at Georgetown University, Washington, D.C. He was previously with the Lima, Ohio, Memorial Hospital.

Joseph H. Liebman, M.D., Frankfort obstetrician, has been elected chairman of the Frankfort and Franklin County Library Board. The Board was organized to determine the feasibility of a community library to be financed by the State of Kentucky, Frankfort and Franklin County. Doctor Liebman is a 1936 graduate of the University of Louisville School of Medicine.

William P. VonderHaar, M.D., Louisville general practitioner, was named the outstanding young man of 1962 January 10 by the Louisville Junior Chamber of Commerce. Doctor VonderHaar was medical chairman of the Sabin oral polio immunization project in Louisville and Jefferson County. The Award referred to Doctor VonderHaar as "the one individual whose untiring efforts made the recent Sabin Oral immunization program such an overwhelming success here in Jefferson County."

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1963 Annual Meeting — Kentucky State Medical Association

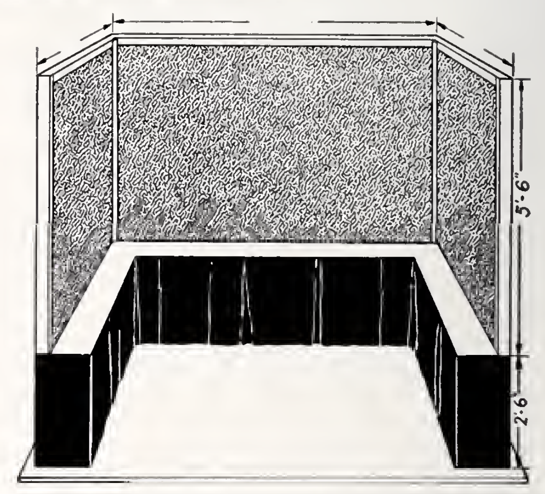
Phoenix Hotel — **Lexington, Kentucky** — **September 24, 25, 26**

Fill Out and Mail to:

J. ALEX HALLER, M.D., Chairman
Committee on Scientific Exhibits
Heyburn Building,
Louisville 2, Kentucky

Applications for space should be received before July 1, 1963

Dimensions and structure of KSMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: ....
2. Name (s) of Exhibitor (s): ....

   ....

   Institution (if desired): ....

   Mailing Address ....
3. Do you have a built-in exhibit? ....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)

   Charts and Posters.... Photographs.... Drawings.... X-rays....

   Specimens.... Moulages.... Other Material .... (Describe)
6. Booth Requirements:

   Amount of wall space needed? ....

   Back wall .... Side walls ....

   Square feet needed? ....

   Shelf desired? (yes or no) ....
7. Has This Exhibit Been Exhibited Before? (yes or no) ....

Date ....
Signature of Applicant

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KSMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

"cleared head—able to breathe through nose"...or how another happy patient describes the nasal decongestant action of Dimetapp Extentabs.* How would your patients describe it?/In Sinusitis, Colds, U.R.I., up to 10-12 hours' clear breathing on one tablet (containing Dimetane® [brompheniramine maleate], 12.0 mg.; phenylephrine HCl, 15.0 mg.; phenylpropanolamine HCl, 15.0 mg.)./Also available: Dimetapp Elixir, for t.i.d. or q.i.d. dosage. **Dimetapp® Extentabs®**

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For some of these patients, the onset of relief from pain was exceptionally prompt. Also, the average recovery time of good-or-excellent-response patients (among those whose recovery time was noted) was just over three days.

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Metaxalone has been studied pharmacologically since 1958. Clinical trials began about a year later. These investigations indicate that Skelaxin blocks reflex spasm and spasticity by suppressing nerve impulses in polysynaptic pathways, primarily in the spinal cord and to a lesser degree at supraspinal levels. It helps restore normal muscle tone without altering posture or gait and without producing sedative, hypnotic, or tranquilizing side effects.

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dosage: For Skelaxin, two tablets t.i.d. or q.i.d. for not longer than 10 days. Dosage for children (6 to 12 years) should be adjusted according to body weight.

side effects: In 1502 patients given daily doses of Skelaxin ranging from 1200 to 9600 mg., 10.5% experienced side effects. These were generally mild, with nausea or gastrointestinal upset being most frequent. Only 0.5% experienced vomiting attributable to the drug, however. Other effects infrequently noted were drowsiness, dizziness, headache, nervousness or "irritability," and a hypersensitivity reaction of light rash. All cleared promptly upon withdrawal of the drug.

precautions: Variations in white cell count and hemoglobin levels have been reported in a few patients. Therefore Skelaxin therapy for more than 10 days is not recommended. A drug relationship was indicated in one of four cases of leukopenia reported in 360 Skelaxin-treated patients. In all cases followed-up, the WBC returned to normal after discontinuance of Skelaxin.

One instance of hemoglobin depression (less than 10 Gm.) which may have been drug-related was reported, in 306 patients; a return to an essentially normal level followed the discontinuance of medication.

One case of jaundice has been reported. Elevation of cephalin flocculation tests in several instances were not paralleled by changes in other liver function parameters. Urinalyses in 280 patients were essentially normal; false positive Benedict's tests, due to an unknown reducing substance in the urine, were reported in 9 patients.

contraindications: Do not administer to patients with known tendency to drug-induced anemia, or give to them only under careful supervision. Not recommended for use during pregnancy.

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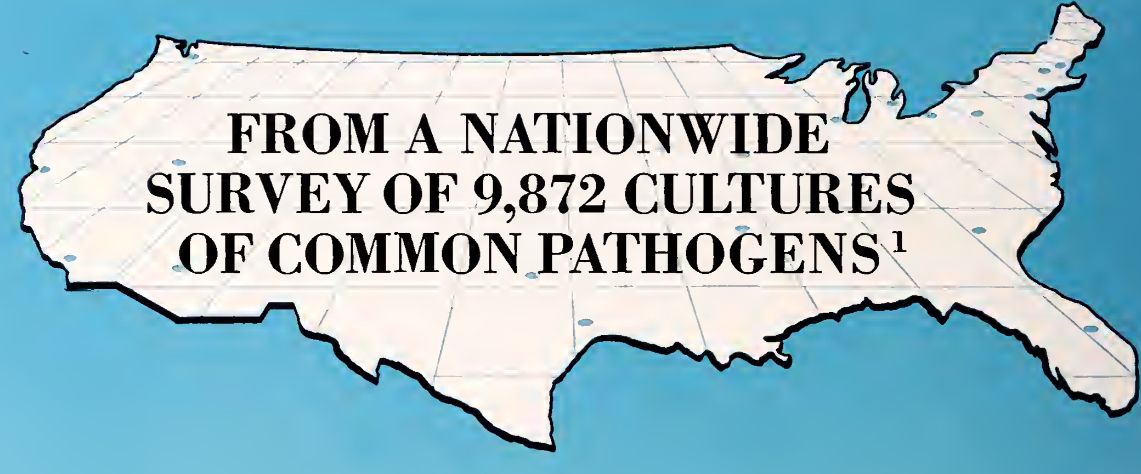
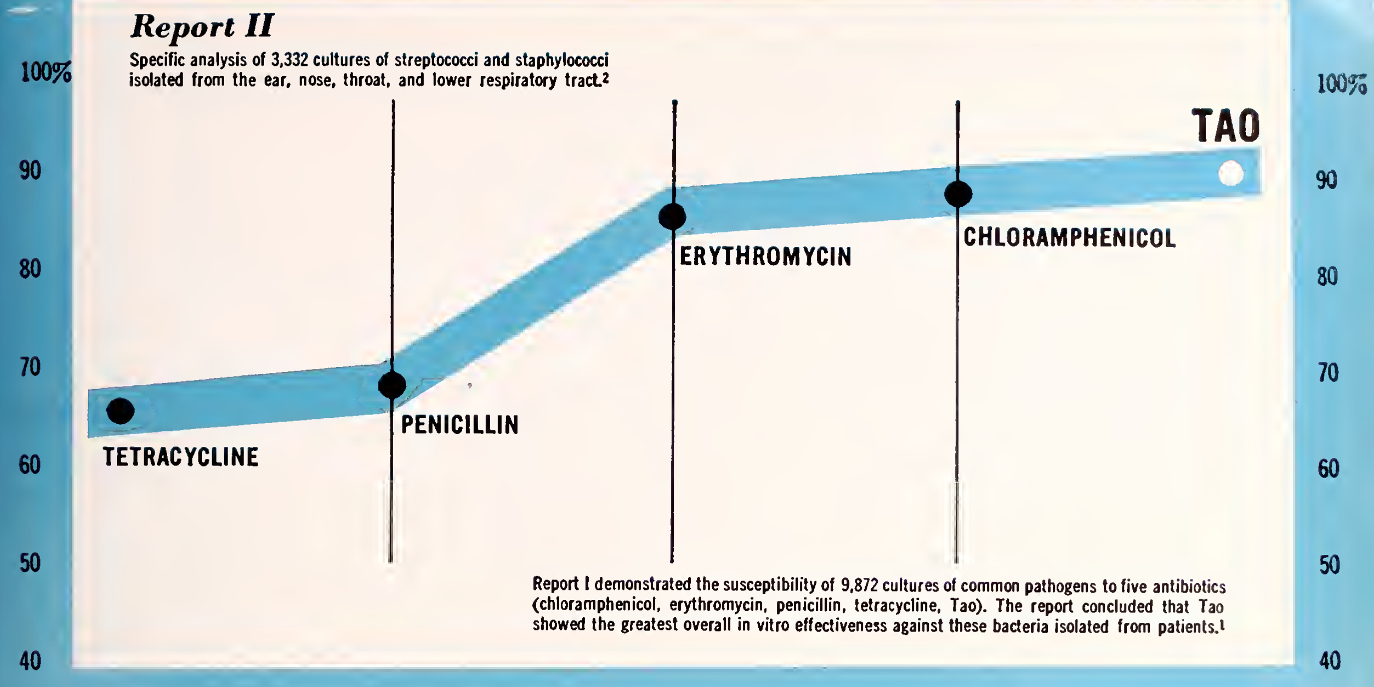


Conclusions of Nationwide Survey: *Report I*

1. **Even after five years of general use, Tao, of** the antibiotics tested, demonstrated greatest activity against respiratory streptococci and staphylococci (3,332 cultures).

2. **Overall results showed a higher percentage of susceptibility** among these common pathogens to Tao than to the other antibiotics. Susceptibility to Tao was greatest, not only in respiratory streptococci and staphylococci, but also in these organisms isolated from skin and soft tissue (3,423 cultures), genitourinary and gastrointestinal tracts and other sources (2,458 cultures). Susceptibility was equal to all antibiotics tested in pneumococci from unspecified sources (463 cultures), and less to Tao in H. influenzae from unspecified sources (196 cultures).

3. **Tao has been used for five years without development of predictable cross resistance.** In 1958 and 1961, approximately 73% and 70%, respectively, of erythromycin-resistant problem staphylococci showed susceptibility to Tao.[3,4] The present study confirms the continuing high degree of Tao activity even against these pathogens. Of 1,592 cultures of erythromycin-resistant staphylococci, 68% were susceptible to Tao, while in the reverse situation, only 33% of 768 Tao-resistant staphylococci were susceptible to erythromycin.



Report II

Results of Bacterial Susceptibility in 3,332 Respiratory Pathogens

References

1. "Bacterial Susceptibility Patterns: A Geographic Survey." Fowler, J. Ralph, M.D., and Watters, John L., M.D. Scientific Exhibit presented at the Annual Meeting of the American Society of Clinical Pathologists, Chicago, Ill., August 31 to September 9, 1962. 2. Fowler, J. Ralph, Watters, John L. and Levy, Arthur M.: Bacterial Susceptibility Patterns as Related to Geographic Variation and Anatomical Source. In press. 3. English, A. R., and Fink, F. C.: Antibiot. & Chemother. 8:420 (Aug.) 1958. 4. English, A. R., and Fink, F. C.: Antibiot. and Chemother. 11:648 (Oct.) 1961.

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Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

Doctor Bean at U. of K.

The 3rd University of Kentucky Medical Center Lecture Series will be held March 7, 1963, at 8:00 p.m. at the Medical Center in Lexington. The nationally-known speaker will be William Bean, M.D., professor of Medicine, University of Iowa. His topic will be "Physicians and Books" with a sub-title, "With Some Notes on Osler."

In Kentucky

FEBRUARY

21 — Monthly University Surgical Day, "Gastrointestinal Surgery," University of Kentucky Medical Center, Lexington, Ky.

22 — Pediatrics Department monthly program, 12:30 p.m., University of Kentucky Medical Center, Lexington, Ky.

MARCH

21 — Monthly University Surgical Day, "Endocrine Surgery," University of Kentucky Medical Center, Lexington, Ky.

27-28 — Symposium on Cardiovascular Diseases, Brown Hotel, Louisville, Ky.

APRIL

1-4 — Kentucky Hospital Association, Annual Convention, Kentucky Hotel, Louisville, Ky.

13-15 — Kentucky Public Health Association, Annual Meeting, Kentucky Hotel, Louisville, Ky.

18 — Monthly University Surgical Day, "Cancer Surgery," University of Kentucky Medical Center, Lexington, Ky.

25-26 — "Thoracic Diseases," University of Kentucky Medical School, Lexington, Ky.

MAY

8-10 — Kentucky Academy of General Practice, Annual Meeting, Kentucky Hotel, Louisville, Ky.

9-11 — "Cardiology," University of Kentucky Medical Center, Lexington, Ky.

10-12 — Kentucky Obstetrical and Gynecological Society, Annual Meeting, Campbell House, Lexington, Ky.

16 — Monthly University Surgical Day, "Surgical Physiology," University of Kentucky Medical Center, Lexington, Ky.

17-18 — Kentucky Surgical Society, University of Kentucky Medical Center, Lexington, Ky.

Surrounding States

FEBRUARY

10 — Seminar on Gastroenterology, University of Cincinnati College of Medicine, Cincinnati, Ohio.

13 — "Recent Developments in Diabetes Mellitus," Marion County General Hospital, Indianapolis, Ind.

21 — "Ophthalmology for the General Practitioner," Indiana University Medical Center, Indianapolis, Ind.

MARCH

6-7 — "Special Problems of the Kidneys and Ureters and Pediatric Urology," The Cleveland Clinic Educational Foundation, Cleveland, Ohio.

12-14 — "Gynecologic Problems in Private Practice," Medical College of Georgia, Augusta, Ga.

13-14 — Obstetrics and Gynecology, Indiana University Medical Center, Indianapolis, Ind.

18-19 — Southeastern Surgical Congress, Miami Beach, Fla.

20 — "One Day Symposium on Allergy for the General Practitioner and Internist," Ohio State University College of Medicine, Columbus, Ohio.

25-April 6 — Anatomical and Clinical Otolaryngology, Indiana University Medical Center, Indianapolis, Ind.

28-30 — Fourth Oklahoma Colloquy on Advances in Medicine: Pulmonary Insufficiency, Oklahoma City, Okla.

29-April 5 — American Academy of General Practice, Chicago, Ill.

APRIL

1-5 — 36th Annual Spring Congress in Ophthalmology and Otolaryngology, Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va.

4 — Seminar on "Premature Care," Good Samaritan Hospital, Cincinnati, Ohio.

10-11 — Clinical Heart Disease, Indiana University Medical Center, Indianapolis, Ind.

A nine month tutorial program in Cardiology, September 15, 1963 to June 15, 1964, will be offered by the Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

Bockus — Gastroenterology
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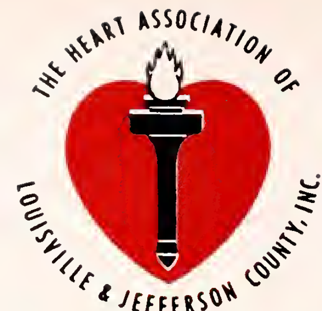

PLAN TO ATTEND
March 27 and 28, 1963

The Brown Hotel—Louisville, Kentucky

9th Annual Symposium On Cardiovascular Diseases

WEDNESDAY, March 27, 1963

MORNING SESSION:

Presiding—GROVER B. SANDERS, M.D., Chairman Symposium Committee, Instructor in Medicine, University of Louisville School of Medicine.

"Bacterial Endocarditis"
PHILIP TUMULTY, M.D., Associate Professor of Medicine, Johns Hopkins University, Baltimore, Maryland.

"Rheumatic Fever"
CHARLES H. RAMMELKAMP, JR., M.D., Professor and Director of Medicine, Cleveland Metropolitan General Hospital, Western Reserve University School of Medicine, Cleveland, Ohio.

"Myocarditis"
C. THORPE RAY, M.D., Professor and Chairman, Department of Medicine, University of Missouri, Columbia, Missouri.

Panel on *"Rheumatic Fever"*
Moderator—KENNETH P. CRAWFORD, M.D., Assistant Professor of Pediatrics and Child Health, University of Louisville School of Medicine.

AFTERNOON SESSION:

Presiding—WALTER S. COE, M.D., Associate Professor of Medicine, University of Louisville School of Medicine; President, Heart Association of Louisville and Jefferson County.

"Anticoagulants"
OGLESBY PAUL, M.D., Professor of Medicine, Northwestern University School of Medicine, Chicago, Illinois, and Past President, American Heart Association.

"Anticoagulants"
VICTOR GUREWICH, M.D., Instructor in Medicine, Harvard Medical School, Boston, Mass.

"Anticoagulants"
JAMES V. WARREN, M.D., President, American Heart Association, Professor and Chairman, Department of Medicine, Ohio State University College of Medicine, Columbus, Ohio.

Panel on *"Anticoagulants"*
Moderator—WALTER S. COE, M.D.

DINNER MEETING:

Speaker—OGLESBY PAUL, M.D.

THURSDAY, March 28, 1963

MORNING SESSION:

Presiding—BEVERLY T. TOWERY, M.D., Professor and Chairman, Department of Medicine, University of Louisville School of Medicine.

"The Use of X-ray in the Identification and Evaluation of Coronary Heart Disease."
DAVID LITTMANN, M.D., Assistant Clinical Professor of Medicine, Harvard Medical School, Chief, Cardiology Services, Veterans Administration Hospital, West Roxbury, Massachusetts.

"The Future Directions of Electrocardiographic Interpretation"
ERNEST W. REYNOLDS, M.D., Associate Professor, Heart Station, University of Michigan, Ann Arbor, Michigan.

"Some Fundamentals of Cardiac Roentgenology"
BENJAMIN FELSON, M.D., Professor and Director of Radiology, University of Cincinnati, Cincinnati, Ohio.

Clinical Pathological Conference
Moderator—IVAN BENNETT, M.D., Professor and Director, Department of Pathology, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Participants: DOCTORS LITTMANN, FELSON, TOWERY and MORRIS M. WEISS, JR., Louisville.

AFTERNOON SESSION:

Presiding—RICHARD R. CRUTCHER, M.D., President Kentucky Heart Association, Lexington, Kentucky.

"Intestinal Angina"
GEORGE C. MORRIS, JR., M.D., Assistant Professor of Surgery, Baylor University College of Medicine, Houston, Texas.

"Aldosterone Secretion in Man and Its Relation to Hypertension and Heart Failure"
JOHN H. LARAGH, M.D., Associate Professor of Clinical Medicine, Columbia University College of Physicians and Surgeons, New York.

"The Relationship of Cardiovascular and Pulmonary Function to Recovery following Cardiac Surgery"
GEORGE H. A. CLOWES, JR., M.D., Professor and Chairman, Department of Surgery, Medical College of South Carolina, Charleston, S. C.

"What's Your Question?"
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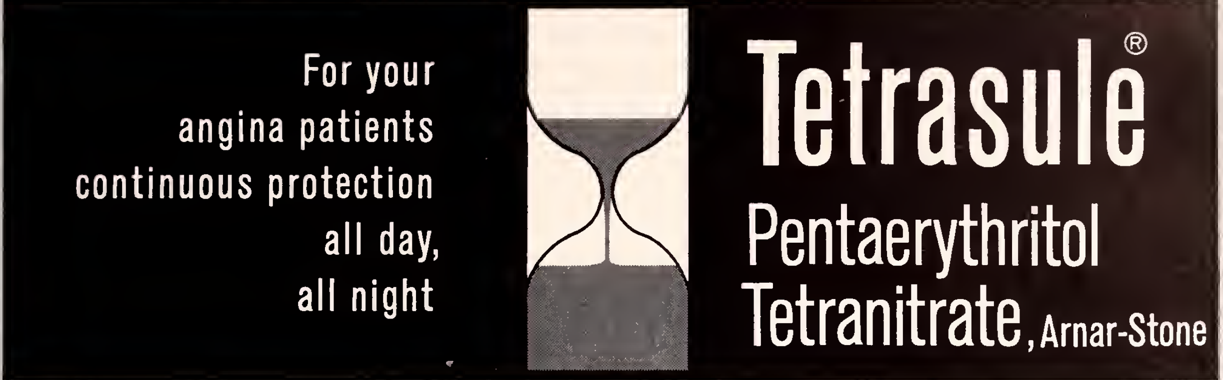

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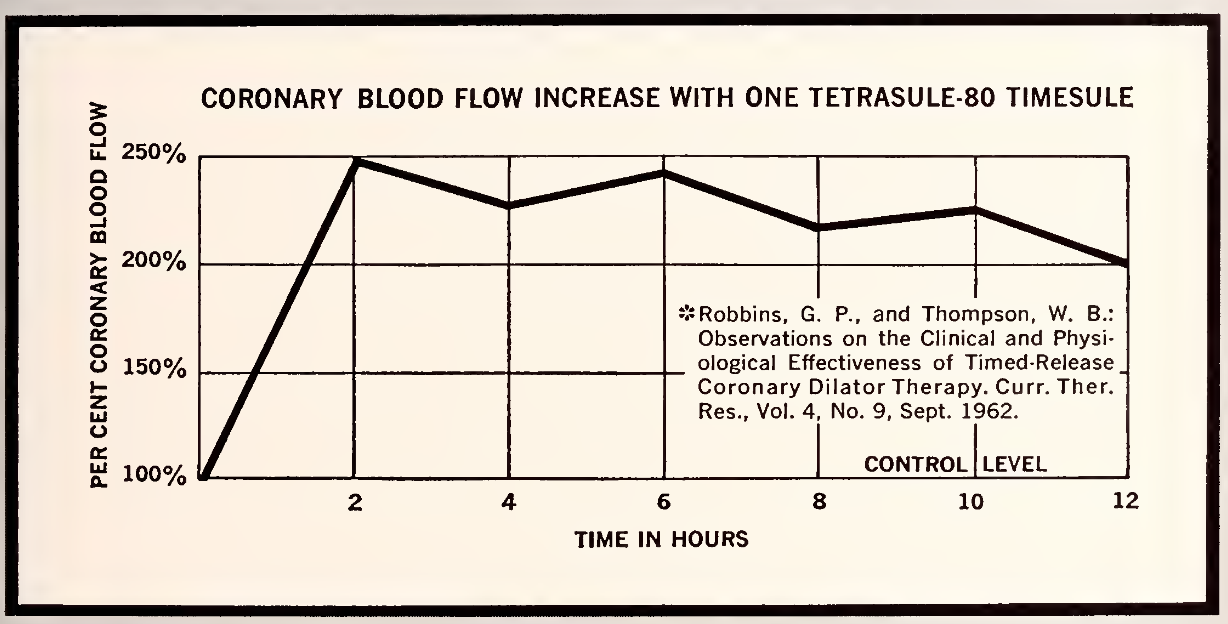

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PUBLIC HEALTH PAGE

Medical Attitudes in the Treatment of Alcoholism*

Russell E. Teague, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

"The character of the physician may act more powerfully upon the patient than all the drugs employed." —*Paracelsus*

A MONTH seldom passes now without an article on alcoholism appearing in a newspaper or general circulation magazine. Invariably these articles emphasize the fact that alcoholism is a disease but, unfortunately, fail to point out that when the American Medical Association termed alcoholism a "disease" their concept of the word was entirely different from the meaning which occurs to the average reader.

As a result of the articles the general medical practitioner can expect two developments. First, as people see and hear again and again the words, "Alcoholism is a treatable disease," there will be an increase in the number of persons asking for help with their drinking problems. Also, along with this problem, the patient will bring with him a concept of disease as a physical entity, with no comprehension of the vital role social, cultural and psychological factors play in the management of any chronic illness. This may well lead to an expectation on the part of many of these patients for specific treatment with immediate and tangible results.

It is not unlikely that these developments will create for many physicians a situation in which they will have to answer some or all of the following questions:

Do I, as a physician, believe alcoholism to be a treatable disease?

Which of the recent developments in drugs and techniques for treating alcoholism should I adopt?

Assuming that I am able to convince the patient that there is no quick, easy, or certain method of treatment, will I then have the time to devote to these cases without reducing my present patient-load?

Am I ready to accept the fact that frustration, disappointments and failures are certain to occur more frequently among these patients than in most other diseases?

Is my personal attitude toward alcoholics such that I can give them the constant and unfailing understanding, sympathy, and support which are critical ingredients of the therapeutic process?

Am I willing to assume the responsibility for admitting and treating them in a community hospital?

Do I recognize the fact that much, or even most, of the patient's illness may be of emotional or social origin rather than physical?

Am I aware of and willing to utilize the contributions which can be made by Alcoholics Anonymous, public health, ministers, and others in the community?

A positive answer to these last two questions is perhaps more important than for some of the others. In the past some doctors have explained their lack of concern with alcoholism through the rationale that laymen, i.e., AA members, are successfully treating this condition, therefore, it is not a disease and thusly not a responsibility of professional medicine.

This viewpoint also gains support from those who point out the lack of clear-cut etiology (or etiologies), the absence of a known cause or agent, and the fact that there is no specific course of treatment. Yet anyone who has made even minimal attempts to help an alcoholic is aware of the great need for doctors who can and will make their particular contribution to an admittedly empirical program of recovery which may also require psychiatric care, vocational rehabilitation, spiritual guidance, marital counseling, economic assistance, legal advice, or maybe, just the social acceptance and sense of worth to be found in AA.

It is not at all surprising that a doctor might, in light of such a list, consider his role relatively small and of short duration, ending with the cessation of withdrawal symptoms. On the other hand, it would be trite here to do more than mention the prevailing philosophy of treating the "whole man" or, as public health puts it, "The Team Approach."

Only a person unfamiliar with the complexity of alcoholism can fail to recognize the multitude of problems facing those who attempt to help an alcoholic. It is almost axiomatic that the physician will have to marshal resources beyond his usual armamentarium. Once he decides to help, however, he has both the challenge and the opportunity to assume leadership in directing these forces toward the relief of an illness which has very serious implications for its individual victims and for society as a whole.

* *This article was prepared by Omar L. Greeman, educational director of the Alcoholism Control Program of the Kentucky State Health Department, Frankfort, Ky.*

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1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

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Meares—Management of the Anxious Patient: Tells you from what sources anxiety in a patient may spring and how it can be resolved.

In Memoriam

MELVIN C. BAKER, M.D.
Louisville
1890-1963

Melvin C. Baker, M.D., 72, Louisville ophthalmologist, died January 3 at St. Joseph Iinfirmary, Louisville.

Doctor Baker was graduated from the University of Louisville School of Medicine in 1914 and served as a lieutenant in the Medical Corps during World War I. He was a past president of the Louisville Eye and Ear Society and of the Louisville Society of Medicine.

NOTLEY CONN WITT, M.D.
Franklin
1880-1962

Notley Conn Witt, M.D., 82, Franklin, Ky., general practitioner, died at his home there December 13. He had been in declining health for several months but had continued to practice.

Doctor Witt was a 1911 graduate of the School of Medicine of Vanderbilt University and served in the Medical Corps during World War I.

MARY E. HOPKINS, M.D.
Louisville
1881-1962

Mary E. Hopkins, M.D., 81, Louisville, retired general practitioner, died December 8 at Methodist Evangelical Hospital.

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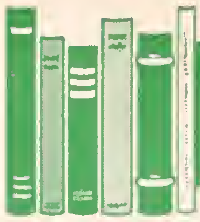

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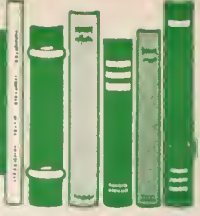

BRAY'S CLINICAL LABORATORY METHODS: (Sixth Edition) edited by John D. Bauer, M.D.; Gelson Toro, Ph.D., and Philip G. Ackerman, Ph.D.; published by C. V. Mosby Co., St. Louis; 594 pages; price, $10.50.

Bray's Clinical Laboratory Methods has long been a favorite with medical technologists. This is because it fulfilled its original object of "bringing together in a small volume for ready reference the most recent information and the most frequently used methods of laboratory diagnosis." Since 1936 (first edition) much information has been added.

This reviewer has found this new edition to contain a wealth of information. The great variety of procedures and methods are well written and easily understood. Many of the newer techniques and procedures are included. This makes it an especially valuable book to have handy in the clinical laboratory.

Much pertinent and valuable data has been reprinted from current medical journals. References are adequate. But it is somewhat disappointing that the editors did not seem to prune out much of the dead wood. For instance, the Tallqvist hemoglobin method still rates a paragraph plus an illustration. Similarly one wonders why the Heller ring test for proteinuria or the icterus index is still included. The Cutler Sedimentation Velocity is another such procedure.

A word about illustrations. Many of the graphs and line drawings, especially the more recent additions, are very good. But there are a number of graphs and illustrations that could stand some "sprucing up" (e.g. Malarial parasites in peripheral blood. Entamoeba histolytica. platelet count).

Despite these several, largely minor, criticisms, I would not hesitate to recommend this volume. It is reasonably priced and fairly complete.

John A. Koepke, M.D.

CLINICAL BIOCHEMISTRY: (Sixth Edition, 1962) by Abraham Cantarow, M.D., and Max Trumper, Ph.D.; published by W. B. Saunders Co., Philadelphia; 776 pages; price, $13.

This book has been the definitive text in the field of clinical biochemistry since its initial publication in 1932. The 1962 edition leaves nothing to be desired in its thoroughness of content and concise, easy-to-read language.

Separate chapters are devoted to the metabolism of carbohydrates, lipids, nucleic acids, proteins, hemoglobin and porphyrins, calcium and inorganic phosphate, magnesium, iron, sulfur, iodine, and trace elements. Other chapters cover the physiological considerations and abnormalities of water, sodium, chloride, and potassium; neutrality regulation; respiratory exchange and basal metabolism; renal function; enzymes: gastric, pancreatic, and hepatic function; malabsorption syndromes; hormone assay and endocrine function; vitamins; and the cerebrospinal fluid.

The book is up-to-date with the current literature in its explanation of recently described biochemical abnormalities in various clinical states. The sections dealing with neutrality regulation, respiratory exchange, and renal function make these rather complicated subjects easily understood. Clear-cut explanations of various disorders of acid-base balance and the mechanism of their production are given. Plasma protein abnormalities and tests depending on globulin reactions are simply and thoroughly explained. Other chapters will not have so frequent use in understanding biochemical errors of disease states but are useful for the occasional reference need.

This text will be of keen interest to the clinician interested in the physiological interpretation of diagnostic aids available in the modern hospital laboratory. It should also prove useful in reviewing the chemical abnormalities occurring in a wide range of illnesses. Particularly helpful are parts dealing with intestinal malabsorption syndromes, enzyme tests, and renal tubular functional defects. Clear, concise coverage of the field of clinical biochemistry should make this book a standard text for the medical student. It will also be of unquestioned aid to the modern physician as a well-indexed reference source.

Will W. Ward, M.D.

CLINICAL DIAGNOSIS BY LABORATORY METHODS (Todd-Sanford): (13th Edition) edited by Israel Davidsohn, M.D., and Benjamin B. Wells, M.D.; published by W. B. Saunders Co., Philadelphia; 1,020 pages; price: $16.50.

For those individuals following textbooks concerned with laboratory diagnosis, it has become evident that there has been a considerable change in the style and material presented. Formerly the majority of emphasis in these books was on technique and little information was given in regard to clinical interpretation, instrumentation, error and new horizons.

This text reflects some of these changes when compared with the previous edition. Considerable emphasis has been laid upon clinical interpretation. Moreover, the classification of laboratory diagnostic procedures has been changed somewhat to conform with disease functions rather than a notation of the test within the laboratory organization.

The text provides an excellent and concise review of hematology and medical microbiology. The area of clinical chemistry is treated somewhat superficially, and clinical and laboratory endocrinology is entirely lacking.

This reviewer feels that this textbook is an excellent addition to the growing library of books concerning laboratory methods and diagnosis.

Marvin Murray, M.D.

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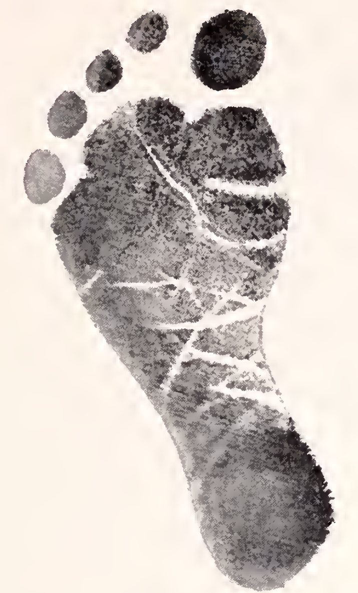

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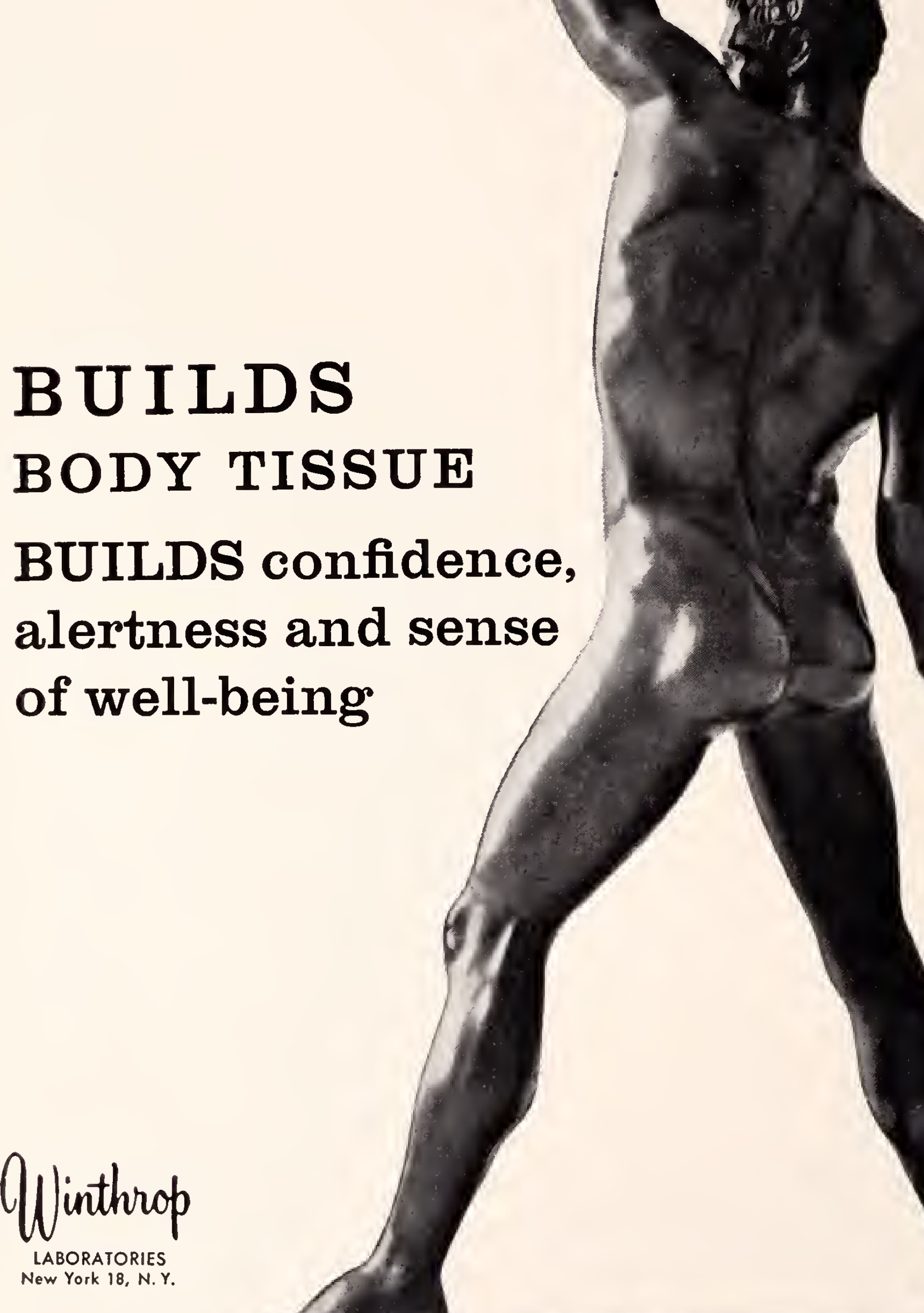

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News Items

William M. Wyatt, M.D., has joined the Somerset City Hospital as pathologist. Doctor Wyatt is a 1945 graduate of the University of Kansas School of Medicine and interned at Kansas City General Hospital. He served for two years as a captain in the Medical Corps of the Army and was a resident from 1949 to 1952 at the University of Kansas Medical Center. Previously Doctor Wyatt was pathologist at the Macon Hospital, Macon, Ga., and associate pathologist at the Flint Medical Laboratory, Flint, Mich. He was in general practice at Borger, Tex., from 1948 to 1949.

Selby Evans Coffman, Jr., M.D., is now associated with the Trover Clinic, Madisonville. He is a radiologist. Doctor Coffman is a 1950 graduate of the University of Louisville School of Medicine and interned at the U. S. Marine Hospital. He served his residency at Duke University Hospital. He was previously at Greenville, N. C.

W. Rexford Duff, M.D., has started general practice at Ashland, Ky., in association with **P. J. Winn, Jr, M.D.** Doctor Duff was graduated from the University of Cincinnati School of Medicine in 1959 and interned at Charleston, W. Va. He previously practiced at Montgomery, W. Va.

Robert H. Scobee, M.D., Winchester, Ky., general practitioner, retired from active practice December 31. Doctor Scobee is a 1926 graduate of the University of Cincinnati College of Medicine.

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JOHN C. QUERTERMOUS, Murray (Alternate)	Jan. 1, 1962-Dec. 31, 1963
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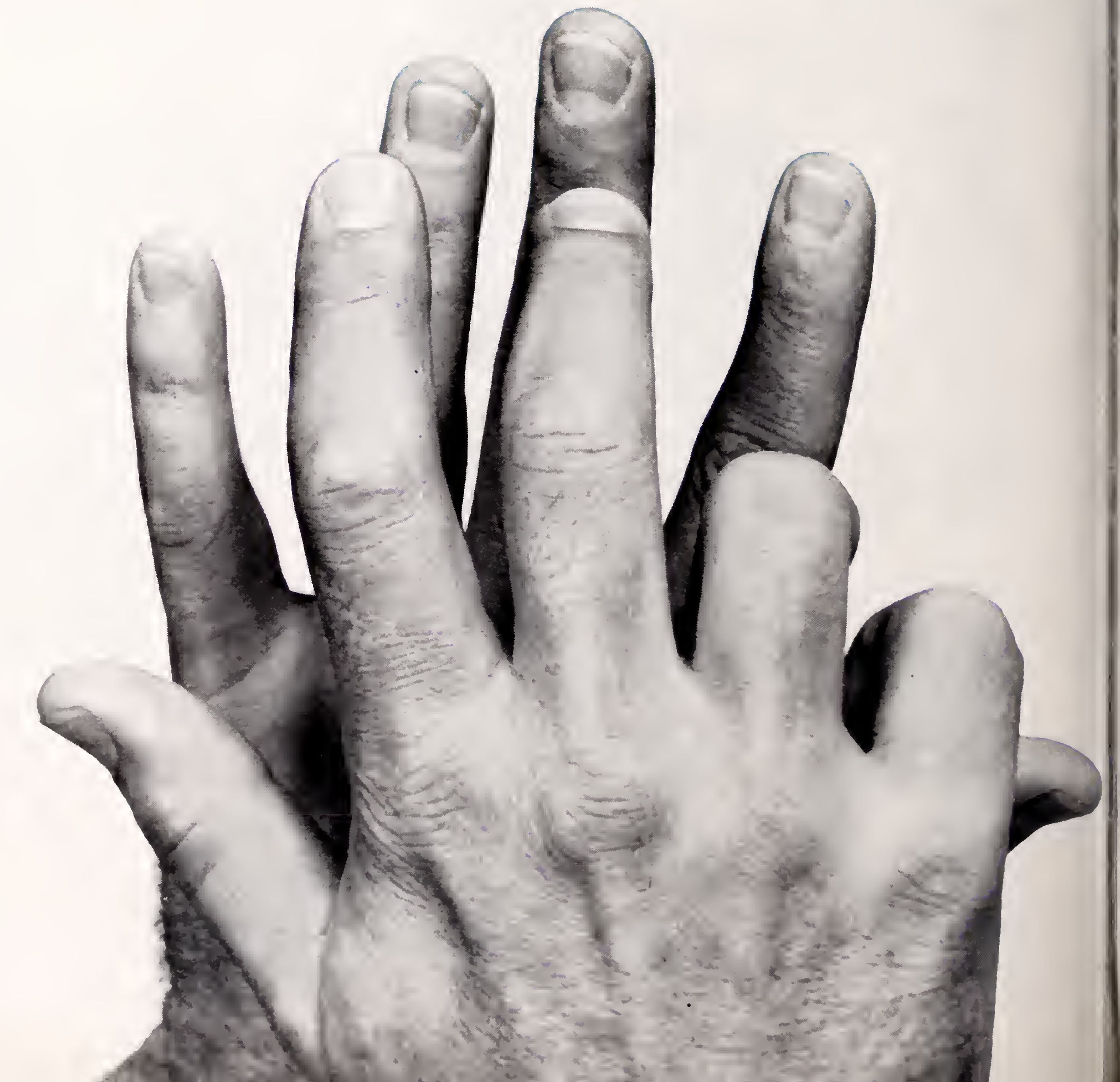

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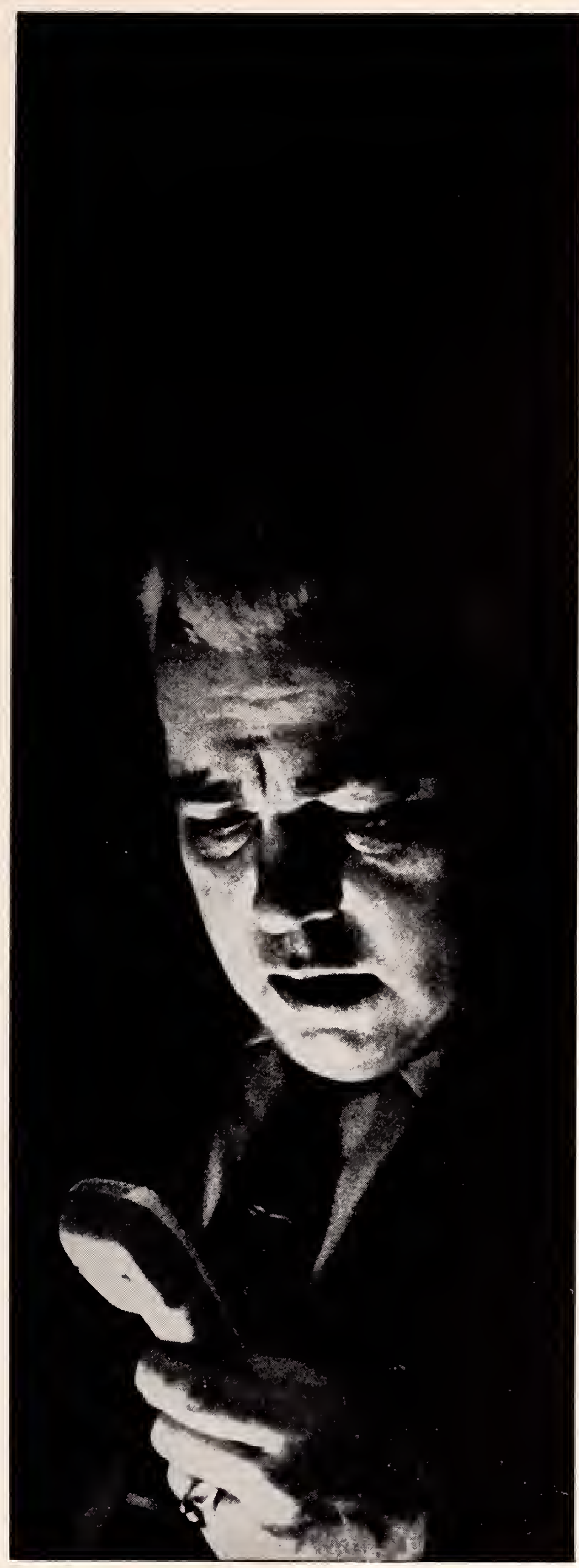

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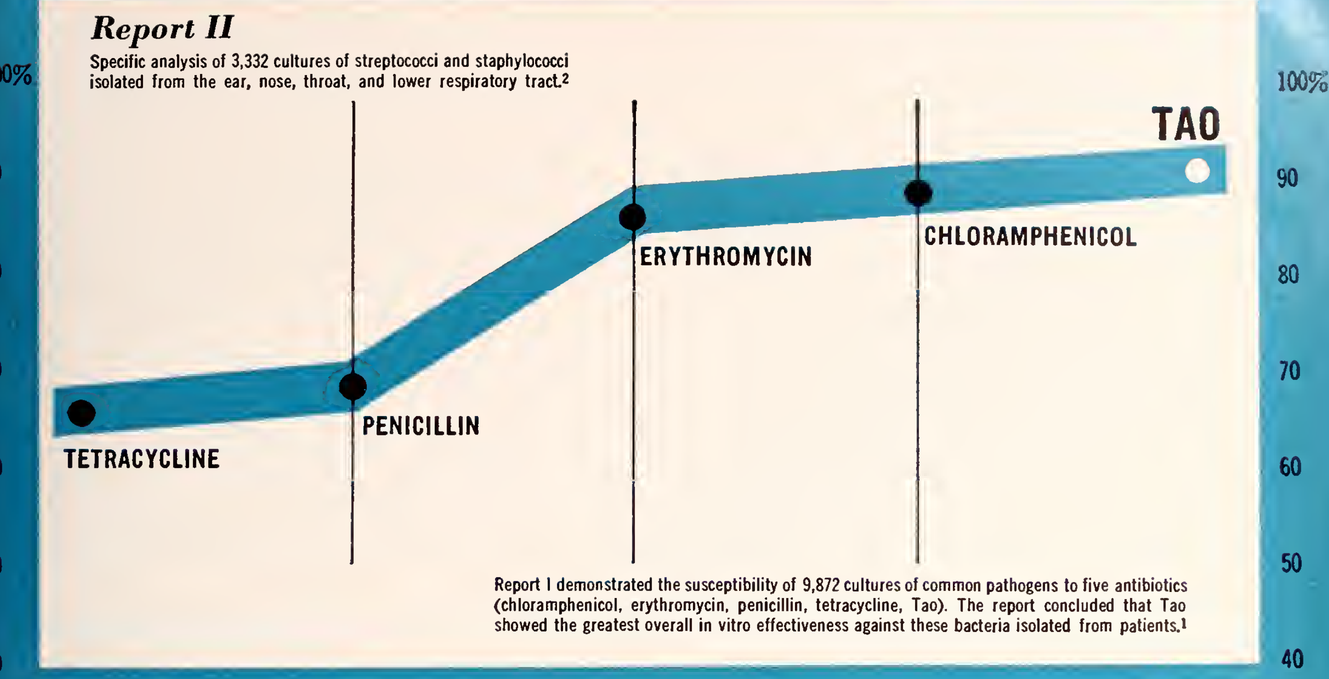

Report II

Results of Bacterial Susceptibility in 3,332 Respiratory Pathogens

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MESSAGE FROM THE PRESIDENT

"Town and Gown" Problems

RECENTLY an exploratory meeting was held concerning "Town and Gown" problems. Representatives from each medical school and the KSMA were in attendance. Each aired his ideas as to a favorable resolution of our apparent differences.

Since the Flexner report in 1909, there has been a continuous change in medical education. Full time teachers have increased yearly. Foundations and wholesale drug companies gave research grants; these were given to teachers to supplement their income. Since World War II, the Federal Government, through the National Institutes of Health, has contributed grants for research to be used by full time men.

The physician in private practice and the teacher have developed in different fields of interest, each sometimes feeling some resentment towards the other.

Both groups are needed to unite their efforts if we are to render the best service and to present the best image to the ever critical public.

The county medical society, the state medical association and the American Medical Association are the official organizations that include all doctors: Specialists-generalists, teachers-private practitioners. United we succeed; divided we lose usefulness, standing and respect.

Our ideal is for every M.D in Kentucky to be a member and take an active part in our various activities. The specialty groups and the Academy of General Practice have their scientific meetings. The KSMA has an excellent scientific program annually.

We have 42 committees that consider many problems including highway safety, civil defense, indigent care, medical services and the Health-O-Rama at the State Fair. We hope to have a full time faculty member on many, or possibly all, of the KSMA committees in the future. Having the assistance of the university members on our committees should not only strengthen them but would contribute to a warmer and better relationship in the "town and gown" area.

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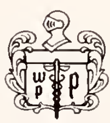

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THE INSURANCE PAGE

Voluntary Health Insurance Subject of AMA Congress

"THE Present and Future Status of Voluntary Health Insurance" was the theme of the Third National Congress on Insurance and Prepayment, which was held in Chicago recently, under the sponsorship of the American Medical Association and its Committee on Insurance and Prepayment Plans.

Many Viewpoints Expressed

Many speakers of outstanding ability, recognized nationally as leaders in their respective fields, appeared on the program to express the viewpoints of groups interested in the problems of paying for health care. These groups included labor, management, commercial insurance, Blue Cross, Blue Shield, closed panel plans and organized medicine.

Understandably, many divergent philosophies were expressed. All of the speakers were agreed on one basic principle, however; which is, that unless voluntary prepayment can solve the economic problems of medical care, public demand and political pressure will inevitably bring about governmental control of medicine.

Doctor McNerney's Address

Any one of the many excellent talks presented at the Congress would merit discussion in this page. One of the most thought-provoking and significant discussions, we felt, was that given by Walter J. McNerney, M.D., president of the Blue Cross Association, in which he pointed out several areas in which voluntary prepayment plans must work to improve their coverage, if they are to survive.

Space does not permit detailed consideration here of the objectives which Doctor McNerney set out, but they can be briefly enumerated:

1. More complete coverage. Voluntary health insurance or prepayment coverage must be made available to *all* of our people who need and want such protection.
2. Extension of benefits. More of the health care services must be brought under the prepayment coverage.
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5. More and better fact finding, so that policy decisions would be based on hard facts, rather than on emotion or intuition.
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WASHINGTON NEWS DIGEST

WASHINGTON, D. C. — President Kennedy submitted to Congress a proposed new multi-million dollar program to combat mental illness and mental retardation calling for the establishment of hundreds of community health centers.

The program would be financed jointly by the federal and state or local governments, similar to the Hill-Burton program for construction of hospitals. It was estimated the program would cost hundreds of millions of dollars eventually, if approved by Congress and fully implemented at the state and local level. Congress was asked to appropriate $31,300,000 in fiscal 1964 for the program.

President Kennedy listed three objectives: 1) Determining the causes of mental illness and mental retardation and finding effective treatments for them; 2) Research and training of skilled personnel; 3) Strengthening and improvement of programs and facilities for treating the mentally afflicted.

"This approach is designed, in large measure, to use federal resources to stimulate state, local and private action," Mr. Kennedy said. "When carried out, reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability. Emphasis on prevention, treatment and rehabilitation will be substituted for a desultory interest in confining patients in an institution to wither away."

The President asked for prompt Congressional approval of legislation that would:

1) Authorize grants to the states beginning in fiscal 1965 for establishment of comprehensive community mental health centers with the federal government providing from 45 to 75% of the project costs and short-term grants for initial staffing costs. The federal government would provide up to 75% of operation costs in early months and phase out such support in about four years.

2) Set up a five-year program, starting with $5,000,000 in the next fiscal year, for project grants to stimulate state and local health departments in planning, in intiating and developing programs. The goal would be prevention of mental retardation.

3) Establish project grants to states to promote public planning for comprehensive state and community action on retardation, plus provision of federal funds up to 75% of the construction costs of mental retardation research centers.

4) Amend the Vocational Rehabilitation Act to provide additional federal financial assistance for services to the mentally retarded and others whose vocational rehabilitation potential is difficult to determine. The legislation would permit rehabilitation services to a mentally retarded person up to 18 months.

* * * * * *

The Kennedy Administration's budget for fiscal 1964 calls for increases for all activities of the National Institutes of Health with a boost of nearly 50%, to $166,000,000, for mental health work.

The estimated expenditures in the new budget for medical research through NIH totalled $850,000,000 more than the estimate for the current fiscal year. The total was somewhat surprising in that President Kennedy expressed dissatisfaction last year when Congress appropriated $100,000,000 more for NIH than he had requested.

In a special message to Congress "on improving American health," the President renewed requests for grants for medical and dental schools, air pollution control, health research, vocational rehabilitation, encouragement of group practice, improving maternal and child care and health and community health services.

He also said there was a "clear and urgent need" for tighter control over the marketing of food, drugs, therapeutic devices and cosmetics.

Mr. Kennedy urged a five-year extension of the Hill-Burton Act providing federal aid for construction of health facilities, due to expire June 30, 1964. He asked an additional $35,000,000 to provide financial assistance for modernizing or replacing hospitals and nursing homes under the law.

He said the need for "high quality" nursing homes would be "especially great" and urged an increase in the budget for such facilities from $20,000,000 to $50,000,000 annually.

The President asked Congress to adopt legislation to abate interstate air pollution along the lines of the existing water pollution control enforcement measures.

The American Medical Association again supported federal aid in construction, expansion and modernization of medical school facilities — "a one-time expenditure of federal funds . . . where the maximum freedom of the school from federal control is assured."

"If the high standards of medical education are to be maintained, increased attention must be given to the adequacy of physical facilities, the availability of qualified instructors and the availability of teaching material and patients for the clinical phases of medical education," Gerald D. Dorman, M.D. told a House Committee. Doctor Dorman is a member of the AMA board of trustees.

"Any attempt to increase the number of medical students without regard to these conditions will result in a lowering of the standards of medical education. At this time, priority should be given, in our opinion, to an increase and improvement in the physical facilities available for medical education."

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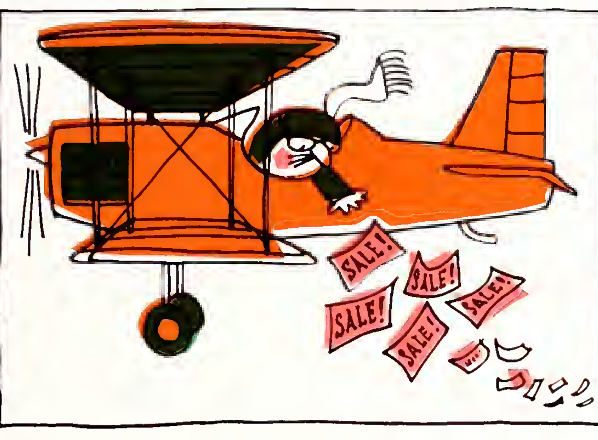

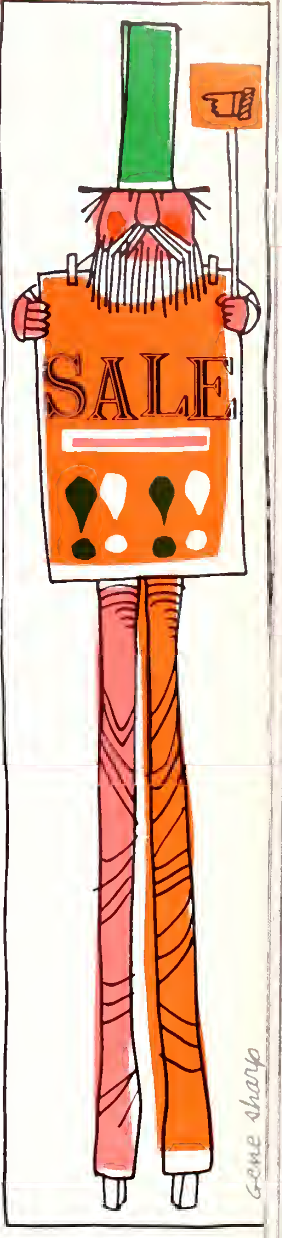

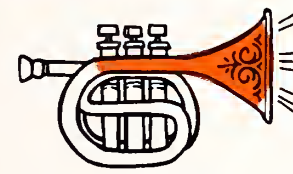

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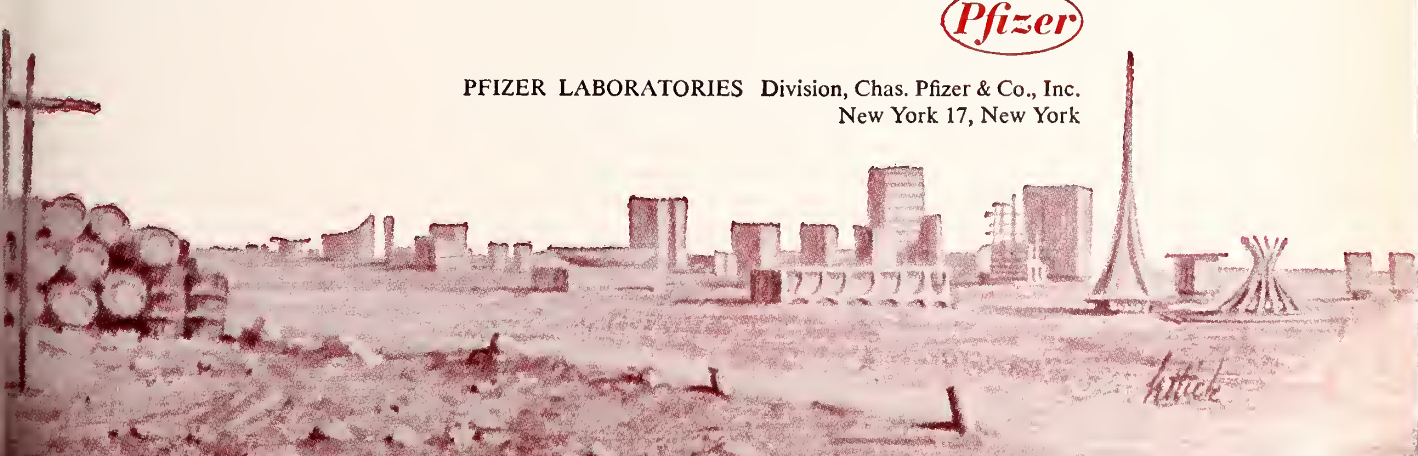

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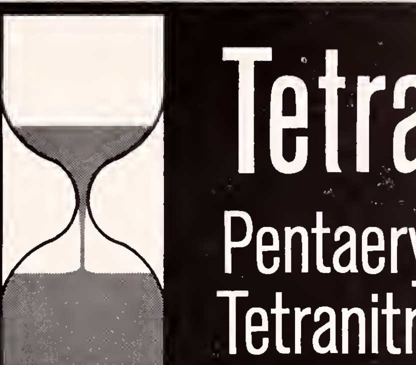

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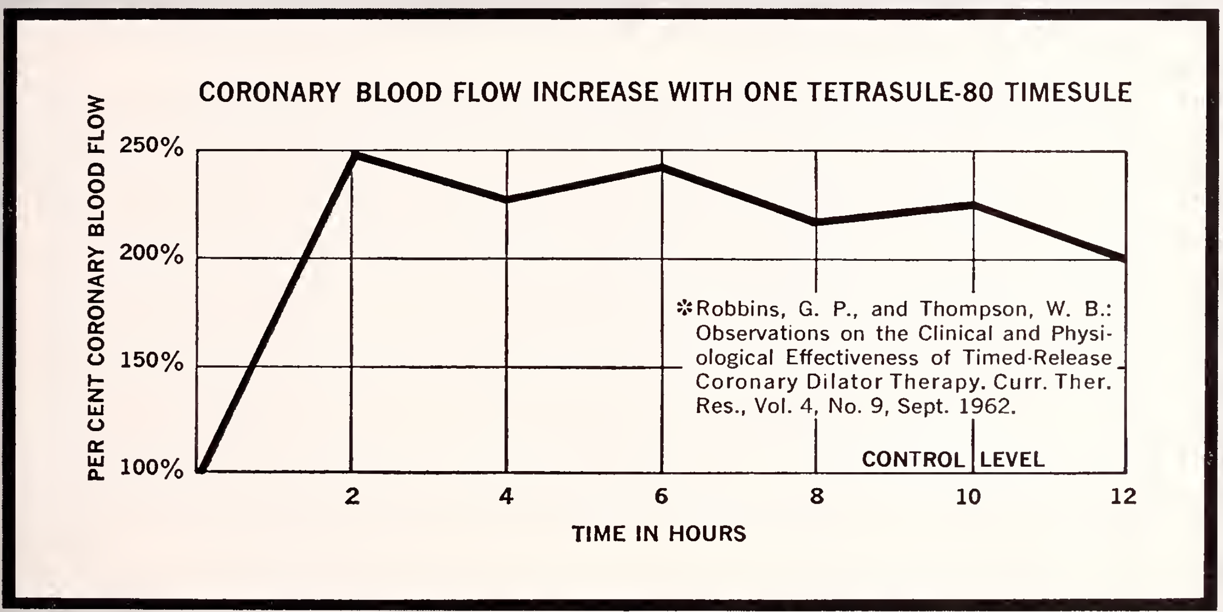

*Robbins, G. P., and Thompson, W. B.: Observations on the Clinical and Physiological Effectiveness of Timed-Release Coronary Dilator Therapy. Curr. Ther. Res., Vol. 4, No. 9, Sept. 1962.

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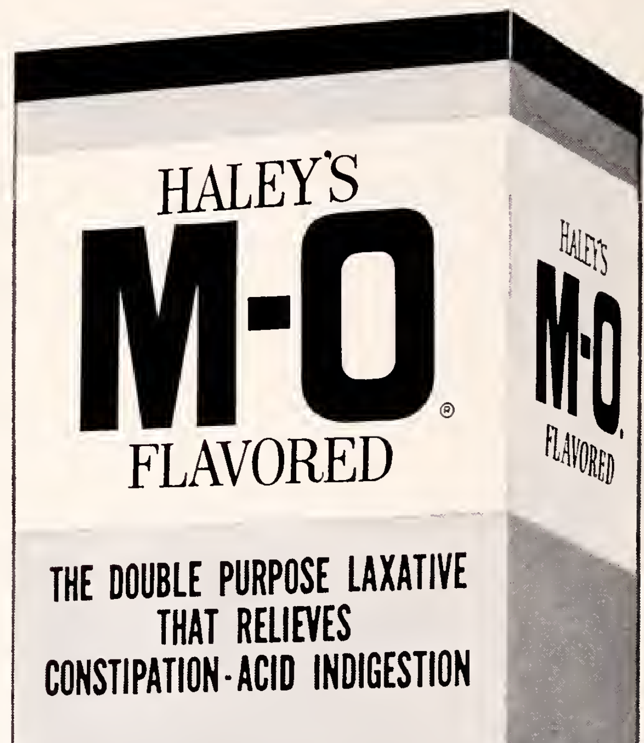

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References: (1) Ernst, E. M.: Current Therap. Res. **3**:167, 1961. (2) Starling, R. J.: J.M.A. Georgia **50**:442, 1961. (3) Sprogis, G. R.: Current Therap. Res. **3**:393, 1961. (4) Coffee, H. L.: Clin. Med. **69**:1561, 1962. (5) Mattey, W. E.: Indust. Med. **31**:33, 1962.

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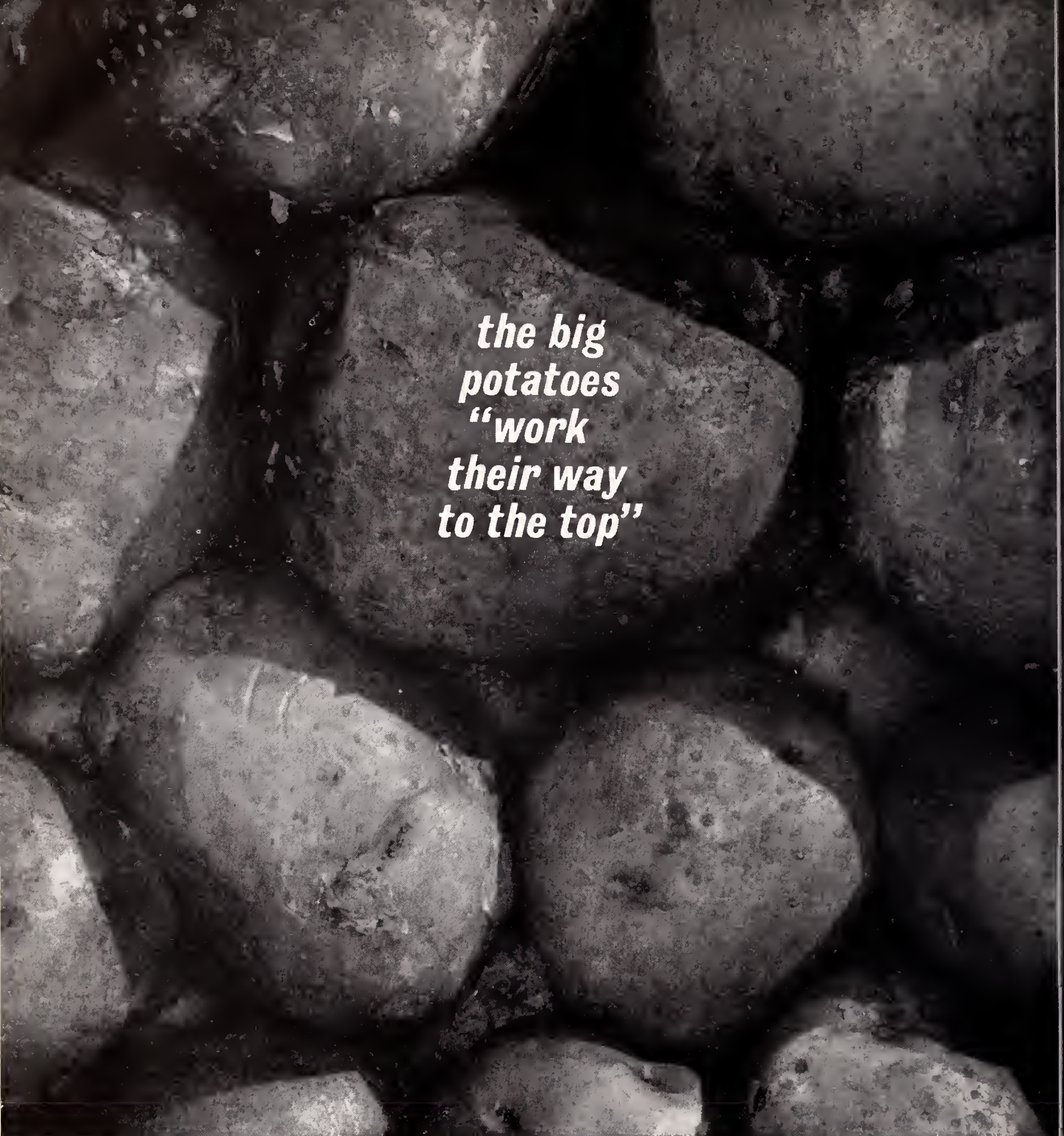

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VOLUME 61 MARCH, 1963 No. 3

Carcinoma of the Right Colon: The Problem of Diagnosis and Treatment*

COLEMAN C. JOHNSTON, M.D., F.A.C.S.†
AND VICTORIANO G. VIRAY, M.D.
Lexington, Ky.

54 cases of cancer of right colon reported. Diversity of symptomatology and difficulty of diagnosis emphasized. 14.8% cases of cancer of right colon caused obstruction; 5.5% had associated cancer of the colon. Time lapsed from onset of symptoms to definitive treatment averaged seven months.

THE subtility, diversity and irregularity of the clinical picture in cancer of the right colon present a difficult though intensely interesting diagnostic problem. The symptom complex may range all the way from a sudden and severe episode of acute intestinal obstruction, through the prolonged and profound anemia, to the silent tumor that has grown quite large to be discovered unexpectedly during a routine physical examination.

It is difficult to picture another single surgical lesion of the abdomen which can masquerade with such versatility, as to play the part of the neurasthenic, the mild cardiac, the dyspeptic, imitate the picture of cholecystic disease, chronic ulcerative colitis, dysentery, diverticulitis, acute intestinal obstruction, or finally, in an advanced state, mimic the healthy man who has only a large palpable mass in the right lower quadrant.

Carcinoma of the right colon, although not uncommon, far too often lies just beyond the horizon of clinical consideration and therefore diagnostic studies are frequently overlooked until late in the course of the disease. Again the barium enema is not infallible in its diagnostic accuracy even in the hands of an experienced roentgenologist, for these lesions of the cecum and ascending colon are often very difficult to discover.

Material Studied

For the above reasons we find the problem of cancer of the right colon worthy of further serious consideration and present an experience to illustrate unusual symptomatology. In addition to this we will discuss the findings observed in a review of 54 patients with carcinoma of the right colon admitted among 219,295 patients hospitalized and treated by the attending surgical staffs of the St. Joseph, Good Samaritan, and Central Baptist Hospitals in Lexington, Ky.

In this study the incidence of carcinoma of the right colon was found to be one in 4,765 hospital admissions. There were 25 men and 29 women ranging from 37 to 80 years of age. The average age was 66.4 years.

In reviewing the signs and symptoms of these 54 patients, 26, or nearly 50% of the group,

Presented at the meeting of the Kentucky Surgical Society, May 25-26, 1962, at Cincinnati.

†Chairman, Department of Surgery, St. Joseph Hospital, Lexington, Ky., and Associate Professor, Clinical Surgery, University of Kentucky College of Medicine, Lexington.

complained of abdominal pain of mild to moderate degree, and 17 patients categorized the pain as cramping in character. In the Lahey Clinic[1] series, 55.6% suffered abdominal pain or discomfort of varying intensity.

Figure 1

Signs and Symptoms	
Anemia (10 gm. or less)	37%
Melena	29%
Altered bowel habit	31%
Abdominal pain	50%
Cramping	31%
Nausea and/or vomiting	18%
Obstructive signs & symptoms	15%
Palpable mass	46%
Duration 3 days to 36 months	
Average duration 7 months	

The variable character of this pain or discomfort may be noted with interest as arising from one or more of three causes; inflammatory change, malignant extension, or intestinal obstruction. Cramping pain suggests either marked irritability, as from the break down products of these often large fungating necrotic and infected lesions, or the presence of impending or intermittent obstruction. Actually 8 of the 54 patients complained of symptoms which suggested the presence of intestinal obstruction.

In earlier years the clinical picture of carcinoma of the right colon was divided into three distinct groups[2]: The dyspeptic patient, the anemic patient, and the patient with a silent mass in the right lower quadrant. At that time little or no consideration seems to have been given the signs and symptoms of the obstructive lesions of this portion of the large bowel, for then this complication was generally conceded to be extremely rare or virtually non-existent.

The reasons, of course, are obvious, for most of the malignant lesions of the cecum and right colon are large, often flattened, partially necrotic, or ulcerating tumors of the bowel wall which protrude into the spacious lumen of this, the largest segment of the colon. The bowel content of this segment of the colon is usually of a fluid or semi-fluid character and bypasses with ease the minor to moderate encroachment upon the lumen of the bowel. It must also be observed that the patient with an acutely obstructing lesion of the right colon was treated as an emergency and rarely reached the large clinics or centers from whence flowed much of the early literature on cancer of the large bowel. Recently in an article by Wilder, Dockerty, and Waugh[3], it was observed that only 20 patients with complete obstruction of the right colon were admitted to the Mayo Clinic between 1910 and 1943.

Review of Symptoms

With the passing of time, our experience began to reveal the presence of obstructive symptoms upon occasion, and after observing a number of completely obstructing lesions of the right portion of the colon, it seemed appropriate to review the more recent literature. In a number of publications the obstructive phenomenon was emphasized. Brown[4] et. al. of the Ford Hospital reported a 27% incidence of signs of obstruction in 60 cases of carcinoma of the right colon.

Burgess[5] found obstruction in 14 of 24 persons with cecal carcinomas, and eight patients of 11 with cancers of the ascending colon who sought medical care because of acute intestinal obstruction. Craig and McCarty[6] found that 43% of their series of cecal lesions were annular carcinomas, while 64% of the group involved the ileo-cecal valve. Nineteen of Brown's 60 cases were annular carcinomas. From these reports, in addition to our own experience, it becomes quite evident that obstruction from carcinoma of the right colon is in reality not uncommon.

In this review of 54 patients studied, a palpable mass was found in 24 patients, while in four this was the presenting complaint. Anemia with a hemoglobin of 10 grams or less was observed in 20 patients. The lowest hemoglobin proved to be 5.6 grams.

Gross blood loss in the form of tarry stools occurred in 11 patients and as fresh blood in the stool of only five patients.

Much of the blood loss may be imperceptible and perhaps, as has been previously observed, there may be a depressant effect upon the hematopoietic system resulting from the toxic absorption from these large necrotic tumors so often seen in the right colon.

Constipation was noted in 10 patients, diarrhea in two, and alternating constipation and diarrhea in five patients. Again, to elicit a history of altered bowel function is a factor of tremendous importance.

The symptoms of weakness in seven and vertigo in three patients were most likely related

to the anemia, or general depletion, but do suggest advanced disease.

Nausea and vomiting, recorded in 10 patients, are usually associated with obstructive phenomena. Though rare, they occur late in the course of lesions of the left colon, but may manifest themselves earlier in lesions of the right colon, because occlusive disease at or near the ileocecal valve, actually simulates, to a degree, obstruction of the lower small intestine.

It is interesting to note that, because of these rather vague and inconstant clinical findings, these 54 patients received definitive surgical treatment on an average of 7.04 months after the onset of the symptoms. One patient came for treatment three days after discovering a mass in the right lower quadrant, while another was treated for intermittent episodes of dysentery for 36 months prior to referral for definitive surgery.

The problem of cancer of the right colon does, therefore, seem to demand more serious consideration than it has had in the past decade or so. Perhaps such a mundane subject has been overshadowed by the many fascinating new developments in other fields of surgery.

The diagnosis of carcinoma of the right colon is, of course, dependent primarily upon a good history and thorough physical examination done by an alert physician with a reasonable index of suspicion. The roentgenologist is ultimately responsible for confirmation, and in early lesions of the cecum, or ascending colon, this is often far from an easy task. Repeated barium enema studies at intervals will often be necessary to discover the small or early lesion. The importance of this is emphasized in the case summaries presented.

Case Reports

In order to illustrate the wide variations in the clinical picture of cancer of the right colon we have chosen as a representative group six of our cases which portray some of the more common clinical pictures that may be observed with this entity.

Case I. The intermittent obstruction.

J. M.: A 57-year-old white male was admitted complaining of intermittent episodes of acute, severe, colicky pain associated with nausea, vomiting, and the appearance of a mass in the right lower quadrant which he was able to feel. After each of these episodes which had begun eight months prior to admission, he observed gratifying relief with the onset of a copious diarrhea. At first these episodes occurred at one- to two-month intervals, lasting six to eight hours, but during the month prior to admission the frequency of his exacerbations increased, with persistent soreness and lower abdominal discomfort. Laboratory studies were: red blood cell count 5,200,000; white blood cell count 8,100; hemoglobin 81%. Roentgen studies of the colon revealed no evidence of disease. Although no mass was palpable on admission, about 36 hours thereafter a typical episode developed and a large, firm, movable mass was felt in the right lower quadrant.

At exploration a partially intussuscepted cecum was found. There was a firm rubbery mass which measured 3 x 4 cms. in diameter at the base of the appendix. A single stage right hemicolectomy was done as an unplanned though urgent procedure, and the lesion illustrated (Figure 2) was found encircling the base of the appendix. This proved to be a large papilliferous adenocarcinoma which explained the repeated episodes of intussusception with intestinal obstruction. Recovery was uneventful and though this patient was lost to follow-up after one year, there was no evidence of extrinsic involvement at the time of surgery.

Case II. The acute abdomen with complete intestinal obstruction.

Figure 2. Papilliferous adenocarcinoma encircling base of appendix within cecal lumen. Instrument protrudes from ileocecal valve which became obstructed following intussusception as tumor progressed forward into ascending colon.

C. P.: A robust 44-year-old white male was admitted at 1 a.m. with acute, severe colic and a tender, rigid right abdomen. Nausea and vomiting were of unusual magnitude. This patient had had several similar milder attacks during

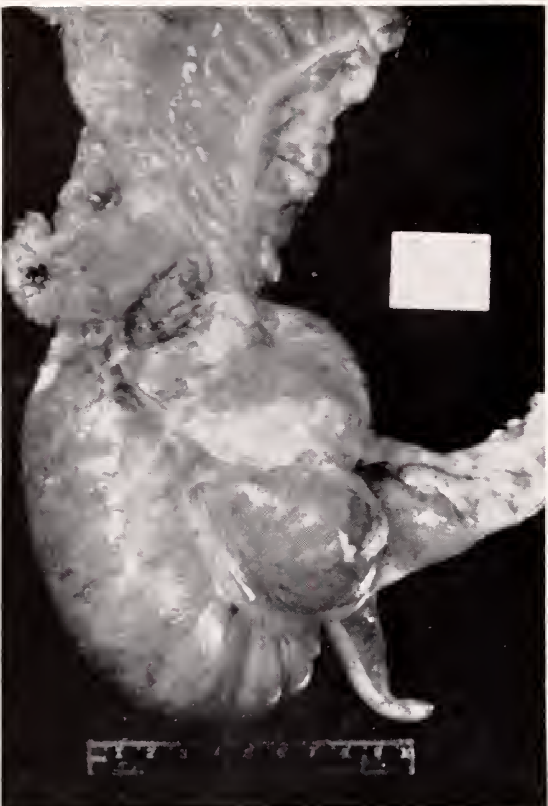

Figure 3. An encircling and obstructing scirrhous adenocarcinoma of the ascending colon. Distended cecum is filled with gas and fluid trapped between obstructing carcinoma and competent ileocecal valve. The terminal ileum and appendix protrude from the right lower side.

the two-month period prior to admission, with general malaise and lassitude during the intervals between attacks. Roentgenograms of the colon two weeks prior to the final episode were reported as negative. The admission hemogram was: red blood cell count 5,300,000, hemoglobin 14.8%, and white blood cell count 9,600. Acute appendicitis, gallbladder disease, or obstruction of the small intestine were considered in the differential diagnosis prior to surgery.

Abdominal exploration revealed an intensely distended cecum with a competent ileocecal valve and an annular constricting carcinoma obstructing the mid-portion of the ascending colon (Figure 3). Because of the competent ileocecal valve, there was no dilation, vascular alteration, or edema of the terminal ileum. The patient was in excellent physical condition, and a right hemicolectomy with a wide mesenteric block dissection was carried out. The lesion proved to be a scirrhous adenocarcinoma with local infiltration and metastases to the regional lymph nodes. The patient is symptom free without evidence of recurrence seven years after operation.

Case III. The patient with prolonged intermittent dysentery.

S. C.: A 78-year-old white male who had undergone treatment for recurrent episodes of severe diarrhea over a period of 18 months was admitted with a history of pain in the right lower quadrant for several months and the recent discovery of a mass in the region. He also suffered from extreme weakness with anorexia and a weight loss of 52 pounds. The initial examination revealed a large palpable tender tumor, 12 x 15 cms., fixed to the lateral abdominal wall, in the right lower abdominal quadrant with a large fluctuant area, about 6 x 6 cms. in diameter, pointing near the right iliac crest. At the time of admission his blood picture was red blood cell count 2,200,000, hemoglobin 5.1 gm., and white blood cell count 13,000. The following day a barium enema confirmed the diagnosis of a mass lesion in the outer wall of the cecum.

Exploration of the abdomen established the diagnosis of a large, fixed, inoperable, nearly perforated carcinoma of the cecum with palpable glands. An ileotransverse colostomy and an excision biopsy of the largest palpable involved lymph node was done. The latter disclosed an undifferentiated adenocarcinoma. During an uneventful postoperative period he was given a course of deep x-ray therapy over the tumor, not so much to alter the course of the malignant lesion, but along with the bypass, to hasten resolution of the extensive inflammatory process which resulted from the near perforation of the cecum. After three and a half months the mass, which had shrunk to one-third the original size, was firm and freely movable. The lesion and a wide mesenteric block were resected with ease (Figure 4). The patient was in excellent health five years after operation and found to have no evidence of local or systemic recurrence at that time.

Case IV. The neurasthenic treated for mild heart disease.

V. H.: A 70-year-old white male who had undergone treatment for six months as a neurasthenic with mild heart disease, presented with prolonged complaints of listlessness, weakness, mild dyspepsia, easy fatigue, and a rapid, slightly irregular pulse. The initial examination

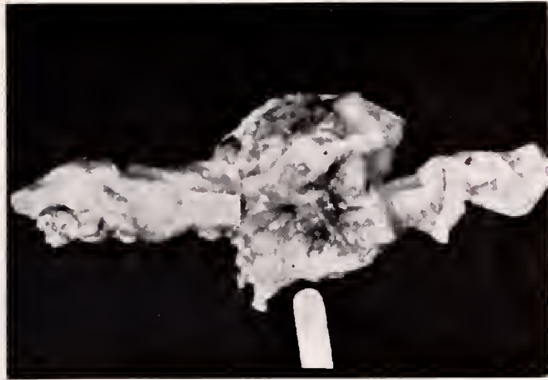

Figure 4. This ulcerating necrotic cecal carcinoma had decreased to one-third its original size following deflection of the fecal stream and irradiation, permitting easy and safe resection.

revealed a movable mass in the right lower abdomen, about 10 x 12 cms. in diameter. On further questioning he admitted to vague abdominal discomfort, gaseous distention and occasional episodes of diarrhea.

The diagnosis of carcinoma of the cecum was confirmed by means of a barium enema. His hemogram evinced a moderate anemia. The red blood cell count was 3,500,000, hemoglobin 9.8%, and the white blood cell count was 9,600. The postoperative course, following a one stage right hemicolectomy, was uneventful. In the large ulcerated lesion (Figure 5) one may easily understand the source of this patient's symptoms arising from the absorption of degenerated tissue substances, associated physiologic alteration, and the slowly progressive anemia. The growth proved to be a Grade 4 adenocarcinoma with local lymphatic involvement. The patient is at this time nine years postoperative and is symptom free with no evidence of local or systemic metastasis.

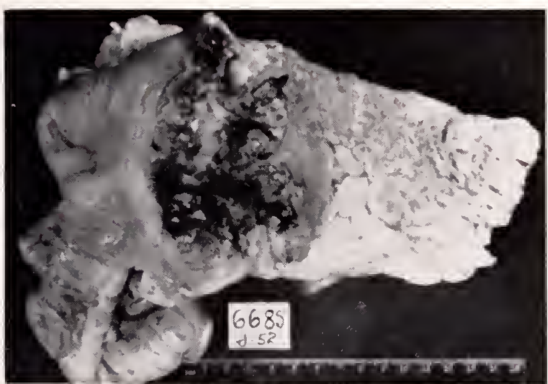

Figure 5. This large ulcerating carcinoma of the cecum with an extensive necrotic base presented as a mass in the right lower quadrant, 10 x 12 cms. in diameter, in a patient treated six months for neurasthenia and mild heart disease.

Case V. The unexplained chronic anemia with the small, elusive, cecal carcinoma.

F. S.: A 65-year-old white female was seen in consultation following a six-months study and treatment for an unexplained anemia. Initially she complained of weakness and chronic fatigue. She noted no pain, discomfort, or alteration of bowel habits though she had always been constipated. No unusual masses were palpable in the abdomen. Her hemogram was red blood cell count 3,360,000; hemoglobin 6 gms.; and white blood cell count 6,350. Other laboratory findings were within normal limits except that occasionally occult blood was noted in the stool. This patient had undergone barium enemas on four different occasions during the six-months period before x-ray studies actually revealed a lesion in the cecum.

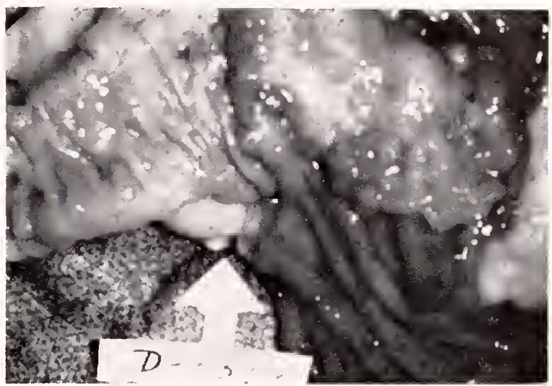

Figure 6. This flattened, oblong sessile adenocarcinoma of the cecum adjacent to the ileum which extends toward the left of the arrow eluded x-ray diagnosis three times during a six-month period. Only at the fourth barium enema was there sufficient evidence to warrant seeking surgical consultation.

At operation a relatively small lesion was found in the posterolateral wall of the cecum. A right hemicolectomy was performed without incident and the postoperative course was uneventful. This patient is well, without evidence of recurrence, though it is only nine months after operation. The pathology report revealed an adenocarcinoma with local metastasis. Figure 6 illustrates the small adenocarcinoma resting upon and arising from the posterior wall of the cecum adjacent to the ileocecal valve.

Case VI. The severe anemia with extensive carcinoma overlooked at x-ray.

H. H.: A 73-year-old white male was incidentally observed to be extremely pale. An inquiry regarding his lack of color evoked only a tired smile and complaint of extreme fatiga-

Figure 7. This x-ray film reveals an encircling carcinoma of the ascending colon undiscovered at barium enema two weeks prior to this examination.

bility. Prompt evaluation revealed a hemoglobin of 6.9%, red blood cell count 3,250,000 and white blood cell count 10,000. Roentgenogram of his colon (Figure 7) revealed a constricting lesion in the ascending colon near the hepatic flexure which was producing almost complete obstruction. A barium enema within the previous two weeks had been reported as negative. Following adequate preparation a one-stage resection of the right colon was done with an end to end ileo-transverse-colostomy. An invasive tumor which encircled the ascending colon was found. It was about 5cm. in diameter, and adherent to the parietal peritoneum of the right abdominal wall. There was no evidence of metastasis. A recent follow-up four years after resection evinced no evidence of local or systemic recurrence.

Treatment

The accepted treatment of cancer of the right colon is, of course, radical surgical extirpation, with as wide a regional lymphatic dissection as is practical and possible. Initial division and ligation of venous channels and the lymphatic systems draining the area of the lesion is a refinement in technique of utmost importance. Omission of this step was common practice until Barnes[7] reported on the physiologic resection of the right colon. As late as 1954, Cole[8] observed that he knew of no surgeon who did a prophylactic ligation of the mesenteric vessels of the ascending and transverse colon as described by Barnes. It is now the generally accepted procedure and it has been a valuable contribution to the treatment of carcinoma in this segment of the large bowel.

Obviously, the single stage procedure is the operation of choice, however, circumstances may arise, as in Case III, when a definitive procedure is neither practical nor possible in the light of seasoned surgical judgment. One should therefore have no hesitation in resorting to less than definitive procedures when indicated.

Pathology

Figure 8

Pathology	
Ascending Colon	56 %
Cecum	35 %
Hepatic Flexure	9 %
Glandular Metastasis	35 %
Gross Metastasis	15 %
Multiple Cancer	5½ %

Of the 54 patients studied, 30 of the lesions were found in the ascending colon, 19 in the cecum, and five at the hepatic flexure.

In 19 patients no glandular metastases were found on pathologic examination. In 27 patients glandular involvement was noted. Five were found to have liver metastases, and in three the second portion of the duodenum was involved. Two patients were found to have an additional carcinoma in the rectosigmoid area and one, a carcinoma of the descending colon and the rectum. In short, a surprising 5½% of these 54 patients had multiple cancers of the large bowel.

In 46, or 83% of the patients studied, the tumor was resectable; in eight patients the lesion was inoperable. Two patients were explored and closed, and in six only an ileo-transverse-colotomy was performed.

Figure 9

Operative Data	
Resectability	83 %
Mortality	11 %
Cause of Death	
Pulmonary Embolism	2
Peritonitis	2
Coronary Occlusion	1
Cardiac Failure	1

There were six deaths in the series reviewed, a mortality of 11%. Although this would seem

to be a rather high mortality, it included the inoperable and palliative procedures, in addition to those operations considered curative. McKittrick[9] reported four deaths in a series of 45 resections for operable carcinoma of the right colon. Two patients succumbed to pulmonary embolism, two to peritonitis, while coronary occlusion and cardiac decompensation accounted for two of the deaths.

It was not possible to record the long-term survival rate in this series, however such data has been amply recorded in an interesting study by Griffin, Judd & Gage[10] who noted a 60.4% five-year survival rate. It is interesting to note that three of our illustrated cases with multiple glandular involvement, have survived seven, five, and nine years respectively. This would suggest the vital importance of earlier diagnosis and resection as contributing to an increased five-year survival rate.

Differential Diagnosis

In commenting on the differential diagnosis of carcinoma of the right colon, tuberculosis, granuloma, diverticulitis, terminal ileitis, and sarcoma must all be recorded. Fortunately treatment in most instances is the same, for often the gross appearance of the resulting mass in situ is indistinguishable from that of a carcinoma.

On one occasion we encountered extensive localized diverticulitis resulting in a large mass diagnosed only as the pathologist sectioned the lesion. Twice reticulum cell sarcomas have been resected to be diagnosed only on microscopic examination. Residual disease or regional glands in reticulum cell sarcoma will usually respond to x-ray or the alkylating agents; however to date we have no such alkylating agents as effective with carcinomatous metastasis. One patient with reticulum cell sarcoma died within six months with widespread metastatic disease resistant to both forms of treatment, following radical resection of the primary growth.

Summary

A series of 54 patients with carcinoma of the right colon has been reviewed with particular emphasis placed upon the diversity of the symptomatology and the difficulty of diagnosis in this subtile and insidious disease.

Intestinal obstruction in carcinoma of the right colon was noted in 14.8% of the 54 patients studied, while 5½% of the group were found to have one or two other cancers of the large bowel.

Six of the author's cases are reported in brief to illustrate the wide variation in the clinical picture observed with this lesion.

The difficulty of establishing a diagnosis of cancer of the right colon by means of the barium enema is noted.

The importance of the physiological resection of the right colon as described by Barnes is re-emphasized.

The feasibility of emergency resection in cases of right colon obstruction produced by carcinoma is commented on.

The occasional necessity of resorting to a two-stage procedure in the complicated or advanced lesion in the debilitated patient is illustrated.

In this series an average of 7.04 months elapsed between the onset of symptoms and definitive treatment. Certainly there is a possibility of improving our five-year survival rate if this figure can be further decreased.

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The Problems of Aging in a Society of Social Conscience and High Economy

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This article deals with the socio-economic effects which massive prolongation of life have brought about. The phenomenon of aging in general is discussed and attempts are put forward toward basic principles in handling the problem of old age in an affluent society.

NEVER before in the history of mankind has so much been written about the problems of aging. The number of books dealing with research into the complexities of aging, old age and senescence is staggering and we can hardly open a newspaper or magazine today without finding some article or essay concerning the problems of aging. It is no exaggeration if we say that the sector of our senior citizenship has become some sort of a minority in this country of minorities.

This article is not intended to compete with the voluminous amount of volumes available in medical, psychological, biological and socio-economic departments of our libraries. I will put the accent on the socio-cultural segment of the phenomenon of aging. However, even this cannot be done without reference to certain publications and research handbooks already in existence.

Denominators of Aging

In the socio-economic sense, aging is regarded as basically the same in all societies. It is always measured in terms of essential productiveness. Societal conditions determine what is essential. Primitive societies attach paramount importance to physical strength and endurance. Some societies in the past have disposed of their unproductive members, including their elderly. Whether or not he or she could still tend the garden plot was the deciding factor in the old Fiji communities. Whether or not they could still keep up with family moves was a criterion for Eskimo and other nomadic groups.

In our American society of material, economic, artistic and intellectual abundance, the least important criterion as to essential productiveness is brawn while intellectual facility is soaring in emphasis. If aging citizens are unable to contribute in any of these areas, however, they are socio-economically old. Their number is growing in geometric proportions. We have, therefore, a new, highly complex and baffling problem which we have scarcely begun to solve.

It is the purpose of this article to contribute to such solution by evaluating the process of aging in its various aspects and by trying to arrive at certain principles by which the psychological and socio-economic problems of aging can be approached constructively.

Aging is an organic process and starts with birth. Life is a matter of continuous evolution. Our interest should be concentrated on the problems of how to direct aging, how to influence it in a constructive way and how to take care of those who cannot live without care.

The Young Versus the Old

The general attitude of human society towards age has been for many centuries a mixture of pity and of honor and respect for gray hair. These feelings are expressed in old student songs like "Gaudeamus igitur juvenes dum sumus" ("Let us rejoice then while we are young") in which we find the joys of the younger generation put opposite the "burdensome senescence" as expressed in the song by the Latin words of "molestam senectutem." In modern songs we find the stress and melan-

choly of the deepening shadows of life expressed in *"September Song"* and *"Autumn Leaves"*, a French creation. The basic melancholy associated with age is expressed in the ancient adage "Whom the Gods love, die early," a translation stemming from a Latin proverb.

What Influences the Pace of Aging in Men

Many efforts have been made to find a common denominator for the assessment of the characteristics of the aged. Our life span is empirically divided in four stages: Childhood, youth, maturity and senescence or old age. Art has forever implemented these stages with symbols of nature that surround us and of which we are an integral part: Spring, summer, fall and winter.

While there is an undeniable biological similarity and comparability between the seasons and man's life there is one frontier where nature's evolutionary potential ends and where man's sociological element begins to interfere with the changes of nature's clear-cut dynamics. Nature in all its beauty and all its seeming organization has no cortex, no soul, no sense of community and no social conscience. Nature knows no beatniks and nature is not troubled with Social Security for the aged.

Attempts have been made to relate psychological phenomena to biological factors and the dependency of the aging process on environmental influences has been stressed by many authors. One thing appears to be reasonable to assume and to accept, namely that we are dealing with a complexity of factors when we attempt to delve in the dynamics of aging. We feel the same complexities would confront an attempt to establish a general denominator of youth.

There are biological, psychological, personality makeup and other genetic and environmental theories, each of which gives only a partial explanation for the variables of age. The pattern which we present at the end of our life is initiated at birth and finally completed as a mosaic of inherited and acquired elements of our total personality. That factor accounts for the multitude of shapes and nuances which we see when we look at aging or old people.

While there is definite physiological and biological evidence of aging and functional impairment pertaining to aging, no one with experience in the field of geriatrics can escape the impressive fact that biological as well as functional factors are ruled, and, if this is the correct terminology, overruled by genetic heritage. It seems to me that if we could change or adjust our genes, the whole problem of aging could be standardized, its pace reduced and its changes deprived of their abruptness. An ideal would be accomplished and the spirit would rule the flesh.

How to Age Gracefully

What has happened to the honor once accorded gray hair? Nowadays old age seems to command only pity, at best tolerance, but no respect. If it is true that the respect of which we are capable reflects our own cultural status then this cultural plateau of our present era has been lowered considerably. We live in an analytical and skeptical era in which people distinguish between a progressive and cumulative life experience of 65 years, and a life experience of one year simply multiplied 65 times. It is only natural, therefore, that the ever-present fear and anxiety in the aging has become even more manifest and in many people has become intolerable.

It is the question of social acceptability which is foremost on the mind of the aging. The old adage of "aging gracefully," beautiful and encouraging as it may sound, has become attainable to an ever-decreasing minority in our present socio-cultural climate. Our goals should, therefore, be in the first place, to find a way of constructive aging which should be open to as many people as possible. The Federal Government and especially the Veterans Administration Voluntary Service are trying hard to find these ways.

Higher Education and Its Effects on Aging

The interest rate which we receive from a life of intelligent educational and cultural investment is high. People of higher education and of higher incentives show a much more gradual transition into the deprivations of old age than those who live a life of non-investment, haphazardness and laissez-aller ("lack of direction").

Today we have around us great living examples of this undeniable truth. Men like

Churchill, Eisenhower, Adenauer, DeGaulle and many others show that chronological aging has little to do with functional aging. The will not to give in to the detriments of old age is conspicuously present in those personalities despite the fact that no one, including these dynamic exceptions, can escape the impairment of cellular processes which is basically and undeniably evident in aging people.

Considering all these seemingly contradictory and unsolved problems this is the obvious question: When is a man actually old? There is no sharp demarcation between normal functioning and senescence. It is a gradual condition and can be considered a disease only when the individual recognizes it and requires help or when the individuals with whom he comes in contact feel that his behavior is no longer acceptable to them.

We live in an era in which an enormous stress has been put on education and in particular higher education. Our universities and colleges are overcrowded and every family strives to have its children take advantage of the blessings which education holds for all. The better our knowledge the better we will be able to cope with the manifold problems of life. Education in the field of old age will have two inescapable and gratifying results. The younger generation will achieve a better knowledge of the causes and contributing factors of aging and will at the same time, with the aid of that knowledge, prepare for a constructive later age when that time comes. Good environmental influences in our formative years will lead to independence and creativity.

The higher our plateau of civilization the easier it is to see the picture of the aged and the concept of aging as a state of transition which replaces a picture of superfluousness with that of respect and understanding. Higher standards of knowledge will create higher incentives and as a by-product, better life habits which we find too frequently lacking among our aged.

In an article written for *Postgraduate Medicine* in March 1961, Morris Fishbein, M.D., states that extensive studies have shown that people who have a high level of education or who are skilled craftsmen show the least deterioration in old age, partly because of the extent of their intellectual and coordinated activities and partly because their work is often independent of any arbitrarily established pace.

The deliberate exercise of mental reserves leads to storage of memories. Stated more simply, people who continue to use their minds deteriorate less than do those who stop. The more creative men are more autonomous and dynamic and at the same time less anxious than the less creative. The truly creative person is simply independent. Outstanding living examples in this category are men like Pablo Picasso, Carl Sandburg, Leopold Stokowski and Doctor Albert Schweitzer, just to mention a few.

In contrast to those mentally active men the majority of our aging citizens are prone to a growing rigidity of habit and outlook which, in turn, results in intense distrust of change, especially in those whose lives have run along a confined path. With this is coupled the fear that change will be inevitable when independence decreases. There is less fear of poverty but there is a terror of becoming dependent on others or of becoming institutionalized.

Unfortunately, it is an undeniable fact that too many families in this country are unwilling to take care of their closest relatives and feel that it is the duty of the federal, state or county governments to accept the care of their relatives. Many of our patients who are now in an institution could be taken care of at home and many beds could be used for other patients if more families would be willing to accept the responsibility which is theirs by law and ethics.

As long as husband and wife are together loneliness is mitigated and boredom for the woman is rare since she continues to use her domestic skills. For most aging men and women the fear of uselessness and boring isolation is far more insistent than the fear of death and it is in isolation that mental deterioration more rapidly occurs.

Prolongation of Life and Its Socio-Economic Effects

The problem which we are facing nowadays is best expressed in a statement made by Otto Von Mehring and Frederick L. Weniger in the *Handbook of Aging* published in 1959. The authors make the following statement: The prolongation of life and the maintenance of health have traditionally been the fervent wish

of all men and the hallowed goal of medicine. Ironically, however, the increasing success in extending the individual's life span through medical means and public health advances is creating a new and taxing problem. The chronic progressive disorders of later life are becoming more prevalent and are creating the prospect of a prolonged medicated or severely disabled survival for a mounting number of aged persons. This fact is bound to place a continuously rising problem on the health, nursing and domestic, and economic and social resources of every community, for it threatens each aging individual with the prospect of an increase in the average duration of final incapacity when the younger generation must carry the old.

Morphology of Aging

The inaugurator of the study of old age and founder of a new medical discipline was Ignatz Leo Nascher, inventor of the term, "geriatrics." In 1914 appeared his monumental, *"Geriatrics"* which summed up the modern medical approach to old age: "To restore a diseased organ or tissue to a state normal in senility but not to a state normal in maturity." The problem is "To add life to years, not just years to life."

In this connection and without going into specific disease entities, it is of great interest to realize the fundamental biological and physiological changes in body structures during the process of aging. The most conspicuous evidence of aging in tissues is a decreased amount of parenchyma and a relative increase in stroma.

Each organ has its own pattern of aging, both morphologic and physiologic. Atrophy of the ovary for example may be so complete that only a small piece of inactive fibrous tissue remains. The aged thyroid gland loses follicles and many of the remaining ones are empty or contain poorly staining colloids. The liver shrinks in size and the stomach gradually secretes less and less hydrochloric acid. In the kidney more nephron units disappear and many of those that remain appear to be damaged. Fat and fibrous tissue accumulate. The voltage of the cardiac impulses drops. The arteries and the arterioles lose their elasticity and resilience and show sclerotic damage. Bones become brittle. The skin gets darker, dehydrated, thinner and loses its regenerative power.

In contrast to these various age changes in most of the organs and tissues the blood remains practically unaltered. On the basis of these morphological changes functional changes take place and the body loses its reserve capacity. It is easy to understand that a decrease of function and a decrease of regenerative ability predisposes the aged far more than the young to the dangers of infection and degenerative changes which become less likely to be reversed as the life span increases.

Mental changes develop either as reaction to physical disabilities or from cerebrovascular changes (strokes and so-called brain syndromes) on the basis of atherosclerosis or chronic alcoholism. In addition we see in the aging organism a definite augmentation of psychic stresses to which every person is exposed. Emotional disturbances in elderly people have been studied in various social groups; they are usually classified as fits of depression, hypochondriasis, restlessness and irritability.

One of the most frequent manifestations of mental-emotional disturbance is the fear of losing potency on the part of the male. In the female it is the fear of no longer being able to enjoy intercourse. A common misconception found in women of all social classes is that the menopause signals the end of a woman's sexual life. Contrariwise some older persons feel relieved to find that they have lost their sex drive, thereby achieving a new serenity. Tranquilizers and energizers have brought about a great advancement and have become a blessing in many cases of depression or agitation.

Emotional and Mental Disorders in Senescence

As a positive step toward the prevention of mental ill health during the later years of life the physician should encourage his patients in middle life to develop activities fostering health, social adjustment and the expression of interest outside their occupation. More and more of the responsibility of preventing and treating emotional disturbances and mental illness in old people will fall on the general practitioner and the internist. Psychiatrists are short in supply but can help the situation by disseminating their knowledge and experience to all members of the medical profession.

In an article about psychiatric management of the aged written by Ivor W. Busse, M.D.,

and John B. Reckless, M.D., published in the *Journal of the American Medical Association* in February 1961, the authors stress their belief that the foundations of mental health in old age are laid down during the middle years. More attention directed to patients in this age group might help to prevent many psychiatric problems in the later years.

Since the older person is less flexible and adaptable in the social world, we should encourage our younger patients to cultivate friendships and preserve family ties during the early and middle years. New psychomotor skills cannot easily be learned in old age, nor can an active pattern of physical recreation easily be commenced. The middle years, therefore, are the time to develop activities fostering health, social adjustment and the expression of interest outside one's occupation.

The identification and treatment of remediable mental diseases in the earlier stages would do much to ease the burden imposed upon psychiatric facilities and institutions by our aging population. The wisdom of involving the family in a position of active partnership in the care of the aged relative is becoming increasingly recognized in geriatric practice. Early and adequate consultation should be had with the family and if the disturbance is potentially severe there should be a frank discussion of the present situation and of possible developments. In cases in which hospitalization is indicated this should be arranged with cooperation of the family.

Age as a State of Mind

Let me finish this article with a quotation from an article published by the Gerontological Research Foundation in April 1960:

"Youth is not a time of life. It is a state of mind. It is not a matter of ripe cheeks, red lips and supple knees; it is a temper of the will, a quality of the imagination and a vigor of the emotions. Nobody grows old by merely living a number of years—people grow old only by deserting their ideals. Years wrinkle the skin, but to give up enthusiasm wrinkles the soul. Worry, doubt, self-distrust, fear and despair—these are the long, long years that bow the heart and turn the greening spirit back to dust.

"Whether 60 or 16, there is in every human being's heart the lure of wonder, the undaunted challenge of events, the unfailing childlike appetite for what next, and the joy of the game of living. We are as young as our self-confidence, as old as our fear, as young as our desire, as old as our despair."

Summary

1. Aging starts with birth and age is an organic and integral part of our life.

2. The pace of aging with its physical and mental changes shows individual variables. These are of a complex nature and greatly dependent on genetic and environmental causes.

3. Better education coupled with good life habits delay the process of physical aging and instill into us confidence, independence and even creativity.

4. Better education leads to better understanding and integration between the young and the old.

5. Institutionalization of the old must be the last resort in the field of care for the aged. Both loneliness and institutional status enhance mental and emotional deterioration.

6. Family and community, not federal or state agencies, are and should continue to be responsible for our aged. Public conscience should be directed towards this goal by physicians, social workers and the clergy.

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Combined Influenzal and Staphylococcal Pneumonia*

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The management of a combined influenzal and staphylococcal pneumonia is a very difficult problem, often leading to a fatal outcome. An illustrative case, with the various pitfalls, is described and discussed.

EVEN with our present-day antibiotic armanentarium, pneumonias are all too frequently managed unsuccessfully, with a significant mortality still prevailing. The distinction between viral and bacterial etiologies is not always easy to establish. The specific bacterial organism is sometimes difficult to isolate and precise antibiotic therapy is frequently a problem.[1] These obstacles are usually successfully overcome.

Combined infection with viral (influenzal) and staphylococcic invaders, however, is a catastrophe which results in a high mortality rate.[2]

The following case illustrates the difficulties referred to above.

Case History

M. B., a 15-year-old girl was admitted to Jewish Hospital on March 29, 1962. The history was that of an acute illness beginning five days prior to admission, with symptoms of fever and naso-pharyngitis. Associated with this she had severe pain in the left hip and lateral thigh, which was attributed to vigorous exercise and doing the "twist," the night prior to onset of the illness.

The family physician had given her procaine-penicillin intramuscularly on two successive days. On the third day the fever became much higher and rales were noted in both lung bases. Chloramphenicol was added in a dosage of 250 mgm. four times a day, orally. The fever persisted and on the day of admission she became irrational and delirious. She was then hospitalized by her physician, who promptly obtained consultation.

At this time she was confused and very restless and had slight cyanosis of the nail beds. She was dyspneic and tachypneic. The heart tones were very forceful and rapid. No murmurs were heard. There were crepitant rales in the posterior lung fields, especially towards the bases; anteriorly the breath sounds were very harsh. There was no coughing. The abdomen was moderately distended, but no masses were felt. All of the deep tendon reflexes were hypoactive. The neck was supple. The pharynx was dry and did not appear to be acutely inflamed.

The hemoglobin was 10.9 gm./100 cc. and the white blood count was 12,750/mm.^{3} with 81 segmented polys, 2 non-segmented polys, 11 lymphocytes and 6 monocytes. The urine showed 3 plus albumin, 30-40 RBC/HPF and 10-15 WBC/HPF.

A portable chest x-ray showed numerous soft infiltrations scattered throughout the lung fields, especially in the lower portions. "Active granulomatous disease" was suggested by the radiologist. An electrocardiogram, except for the tachycardia, was normal. The initial bacteriologic studies were reported as showing a gram negative rod in the sputum and in the blood culture. This was later identified as a Proteus. The urine culture was negative.

The antibiotic treatment consisted of continuing the chloramphenicol, adding 1,000,000 units of penicillin q 4 h until the bacterial report was obtained. At that time, intravenous tetracycline, streptomycin, and triple sulfa were started. The patient's condition remained critical and deteriorating, and she expired 48 hours

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after admission, despite supportive measures including intravenous methylprednisolone.

Shortly after her death the laboratory reported the growth of coagulase positive staphylococcus in the second blood culture and sputum specimen. Studies were later reported indicating sensitivity of the organism to a wide variety of antibiotics, including penicillin, erythromycin and Chloromycetin®.

At autopsy the pertinent findings were limited to the lungs. These were described as follows: "The right lung weighs 680 grams and left lung weighs 650 grams. Both lungs are identical in appearance. Each lobe of both lungs reveals areas of hemorrhagic infarctions and varying sized, scattered, firm nodules. Pleural surfaces have adherent fibrous strands and petechial-like hemorrhages. Infarcted areas and varying sized nodules are evident on the surface. On sectioning, lung reveals firm cut surface with varying sized firm nodules and numerous areas of hemorrhagic infarctions. The bronchi and their branches contain no mucus or any kind of material. The bronchial mucosa is congested. The pulmonary artery and its branches contain post-morten clots and reveal no lesions. The nodules in the lungs measure from 0.5 to 1.2 cm. in diameter. No material is expressed upon compression of cut surfaces. Hemorrhagic infarcted areas measure from 1 to 8 cm. in greatest diameter."

Microscopically: "Sections from the lungs reveal the most significant findings and the cause of death. In many areas, there is a necrosis of the bronchiolar epithelium associated with abscess formation, septic thrombi, diffuse pulmonary edema and interstitial hemorrhage. Clusters of bacteria are present in the large abscesses that are found in many areas of the lungs. Little functional pulmonary tissue is left. These findings can be explained on the basis of influenza-staphylococcal pneumonia. We associate bronchiolar ulceration and necrosis plus pulmonary edema with an influenzal infection. This provides the focus of entry for pus-forming staphylococci and subsequent bronchopneumonia, with pulmonary abscesses and septic infarction rapidly ensuing. In many of the abscesses and also in the areas of septic infarction, colonies of bacteria can be demonstrated in these sections. The hemorrhage can be explained on the basis of a necrotizing bronchiolar arteritis. Sections from both lungs reveal similar findings."

The cultures of the lung tissue yielded a mixed growth of coagulase positive staphylococcus aureus, enterococcus, and E. coli. Isolation of pure staphylococcus culture revealed it to be sensitive again to a wide group of antibiotics.

Discussion

Although primary staphylococcic pneumonia may be encountered rarely, it usually occurs secondary to influenza,[4] and has been regarded as a dreaded complication with a high mortality rate since the days of the influenza epidemic of 1918.[5]

It has been suggested that the administration of antibiotics to those with uncomplicated influenza may predispose the patient to a staphylococcic pneumonia.[3]

The pathogenesis of the combined pneumonia has been well explained by Miller and Ray.[2] It consists of a necrotizing, ulcerating bronchiolitis, which is the characteristic pulmonary lesion of influenza,[6] upon which the staphylococcic superinfection leads to necrosis of the bronchiolar wall. Extension of the necrotic, suppurative process into the adjacent tissue produces focal necrosis involving lobular arteries. Septic thrombi thus formed are seeded throughout the lung tissue. Abscesses and empyema develop as the process continues. Treatment with antibiotics, even after appropriate sensitivity studies, may fail to be lifesaving inasmuch as massive inflammatory edema and toxemia may cause death before the antibiotic has had time to be effective.

Steroids may help to reduce the inflammatory process and allow the needed prolongation of time for effectiveness of therapy, while at the same time general supportive measures including fluids and oxygen are maintained. At best, however, in the fulminating form, treatment is very unsuccessful not only because of the prevalence of resistant strains of the bacteria, but because of host factors, as yet poorly understood, which increase susceptibility.[7]

In this case, the initial report of the gram-negative rod in the sputum and blood culture is difficult to explain, in view of the subsequent definite growth of coagulase positive Staphylococcus aureus in the sputum and blood cultures. The most likely explanation is a super

infection with the Proteus, with delay in appearance of the staphylococcus due to the previous antibiotic therapy.

The treatment directed at the Proteus was apparently effective since culture of the lung tissue at autopsy grew out only Staphylococcus aureus, coagulase positive, enterococcus, and E. coli., the former predominating. Since the staphylococcus was sensitive to the antibiotics used, their ineffectiveness is probably attributable to failure of penetration into the infarcted, abscessed areas of the lung.

This case illustrates the difficulty in making a definite etiologic diagnosis as well as instituting effective therapy.

Definite proof of the influenzal infection in this case rests upon the characteristic histologic lesion in the bronchioles rather than serologic testing, but these anatomic changes are sufficiently characteristic as to leave little doubt about the underlying illness.[8] The eventual culturing of staphylococcus in the blood stream as well as from the lungs at autopsy confirms the association of the staphylococcus.

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Vertical Pin and Plaster Fixation for Unstable Ankle Fractures*

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Vertical pin fixation for unstable ankle fractures has been used successfully in nine patients. As a new procedure, not previously reported in this country, it is being designated until further investigation as the L.R. (last resort) treatment.

VERTICAL pin fixation at the ankle consists of the drilling of a medium-sized Steinmann pin upward through the heel and across the ankle joint. An extensive review of the medical literature over the past decade reveals but one article,[1] in Italian, describing this method. As far as could be determined no instances of its usage have been reported in this country.

Modern orthopedic textbooks state that treatment for fractures at the ankle is either by closed or open reduction and that in certain fractures the open method with internal fixation is mandatory. In many patients, however, due to severe associated injuries or to local soft tissue trauma, such surgery cannot be performed. Pin and plaster immobilization in such circumstances often provides the answer. It has the simplicity of closed reduction yet gives positive post-reduction stability comparable to that obtained by open reduction.

Basic Requirements

Success in the care of ankle fractures requires accurate reduction and secure fixation. In addition, an exact diagnosis must be made by determining the condition of the three major ligaments (medial, lateral and distal tibiofibular) and the four malleoli (medial, lateral, anterior and posterior). Not being discernible by x-rays the ligamentous injuries are the more difficult to diagnose.

The condition to be treated, therefore, is a combination of ruptures, avulsions or fractures of any of the above structures plus occasional concurrent fractures of the talus, calcaneus and distal shaft of the tibia. The operator must choose the best method to reduce and to fix that specific grouping of bone and ligamentous disruptions in that particular patient. Furthermore, consideration must be given to many factors including associated injuries, time since accident, local skin and circulatory conditions, the patient's age, sex and size and even his social and economic status.

I have purposely eliminated, in this report, children's fractures, stable malleolar fractures and ankle injuries which may be treated by internal fixation of the medial, lateral or posterior malleoli in the usual fashion. Vertical pin and plaster immobilization should be reserved, in general, for those cases which cannot be treated effectively by orthodox methods.

The use of skeletal bone fixation by pins came into disrepute due to the Roger Anderson and Stader procedures which were popular just before, during and immediately after World War II. Both required wholesale insertion of large pins into cortical bone. Soft tissue irritation at the pins was common and an occasional bone infection also developed. Non-union was not infrequent. Indiscriminate use by too many inexperienced men in too many fractures caused the entire idea to be abandoned. There is, however, definite merit in pin fixation used in certain fractures involving the ankle joint. In general, if the application is not unduly difficult, if the complications are rare and if the results are good, then a procedure is worthy of investigation.

Vertical pin fixation, nevertheless, does violate definite principles of fracture treatment by

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penetrating the articular surfaces of a weight-bearing joint. The advantages, however, far outweigh the possibilities of a late joint reaction. Even so, I favor orthodox methods for ordinary ankle injuries and have designated the vertical pin procedure as the "L.R." (last resort) treatment.

Indications

Indications for the use of the vertical pin include:

(1) Comminuted fractures of the distal fibula with complete rupture of the medial ligament and lateral displacement of the foot.

(2) Ankle fractures with severe circulatory deficiency.

(3) Severe fractures in the extremely elderly patient.

(4) Unstable bi or trimalleolar fractures in which open reduction with internal fixation is usually done but cannot be performed due to patient's poor general condition or to the state of the skin and underlying soft tissues.

A reliable internal fixation is accomplished with this pin by a short simple procedure without a skin incision. Since the sole of the foot is rarely involved with fracture blisters or direct trauma the pin can be inserted in cases in which the condition of the skin at the ankle would not permit a routine open reduction. It may be left in situ through a series of plaster changes or it may be removed in a matter of seconds with the plaster casing being left on for further immobilization.

Obviously the disadvantage of this method is the introduction of a foreign body, small though it be, through the articular weight-bearing surfaces of the talus and tibia. The eventual reaction of such pin penetration will not be known until enough patients so treated can be observed over long periods of time. However, I have often observed complete functional recovery at the knees and ankles following fractures in which the articular surfaces were disrupted and never anatomically reduced. One can recall dozens of instances in which a Smith-Peterson nail or Knowles pin has penetrated the femoral head into the hip joint following a mild collapse of a femoral neck of intertrochanteric fracture. The nail or pin is usually left in place until the fracture heals and upon its removal the clinical result at the hip is usually good. If these joint surfaces can recover from such massive insults then the chances of this 7/64" pin penetration causing permanent joint damage is probably remote.

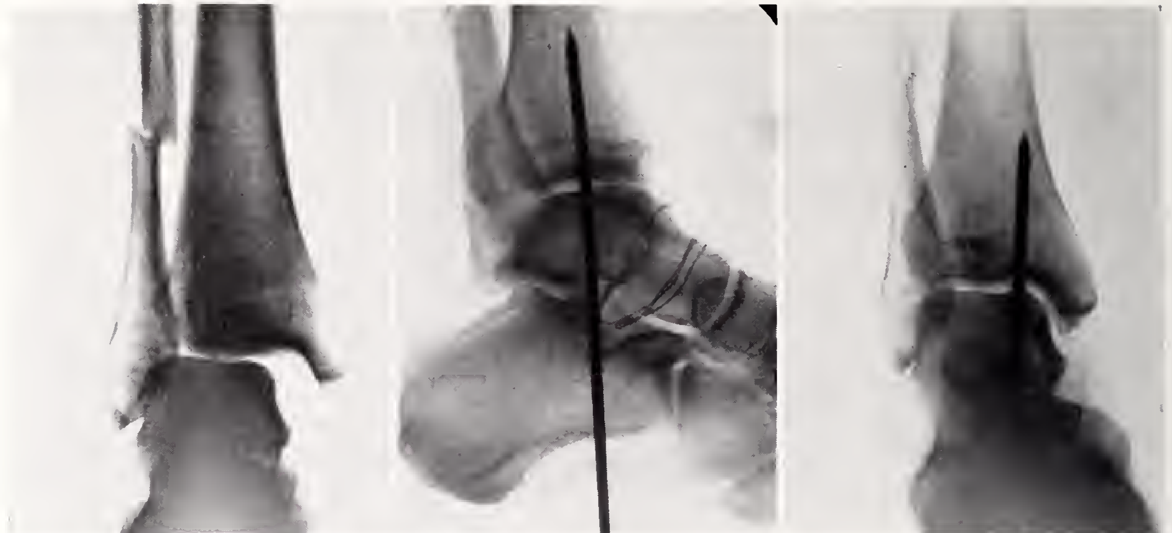
Technique

The technique for use of the vertical pin is as follows: with the knee flexed about 45 degrees over a wooden block the fracture-dislocation at the ankle is reduced in the usual manner with the joint being put into a mild equinus. This position not only aids in obtaining and maintaining reduction but it also allows the pin to penetrate the posterior portion of the dome of the talus. X-rays are made to verify the reduction. The pin is drilled slowly upward into the calcaneus through the silent area between the articulating facets of the calcaneus and talus and then through the talus across the ankle joint and into the tibia for about four inches.

Thermal necrosis is not a problem as this drilling through these cancellous bone areas is done with slow rotation and only mild pressure is required. About one-half inch of the pin is allowed to protrude through the skin at the inferior heel. Under no circumstances should the pin be incorporated in the plaster casing. A hole is cut in the plaster around the pin and a small metal guard placed over it for protection. The usual quadriceps and hamstring exercises and ambulation with crutches may be started promptly. If the plaster casing becomes loose a light snug-fitting cast is re-applied. No weight bearing under any circumstances should be allowed at the affected ankle until the pin has been removed.

Case Reports

Case 1. A white male, age 49, 5′10″ tall, weighing 220 lbs., on February 6, 1961, fell on ice, sustaining a severe fracture-dislocation at the right ankle. Upon hospitalization roentgenograms revealed a comminuted fracture at the distal right fibula with a marked widening of the ankle mortise. He was given spinal anesthesia but reduction of the dislocation was not possible due to interposition of the medial ligament. Open reduction was then done and the deltoid ligament was found to be completely ruptured and lying within the ankle joint. After its repair by silk sutures the ankle remained unstable.



Case 1.: (left to right) The first picture shows the deformity at the right ankle. The additional two pictures show reduction and fixation by vertical pin.

As a last resort to obtain immobilization a Steinmann pin was drilled vertically up through the calcaneus across the ankle joint into the tibia. This gave excellent stability. A plaster boot was then applied with a hole cut out around the pin. Five weeks later the pin was removed and another plaster boot applied which was taken off in three weeks. Physical therapy was then started and the patient returned to work three months after the original injury.

Final examination made 18 months after the date of accident showed the mortise of the ankle to be slightly widened but all motions at the ankle and foot were completely normal, with no areas of pressure tenderness or swelling. He works 40 hours weekly, standing at a machine, without any complaints and considers himself to be completely recovered.

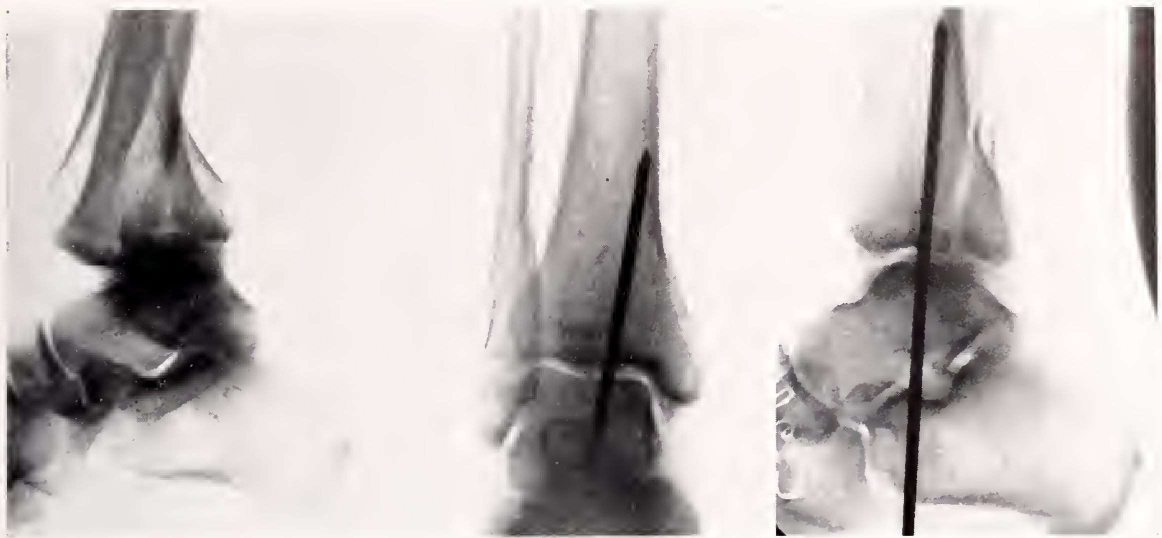
Case 2. An ex-Marine, white, male, age 45, 5′10″ tall, weighing 194 lbs., sustained a severe injury to the right ankle on January 2, 1962. He fell on ice but did not summon any medical aid and was not hospitalized until 18 hours after the injury. Upon examination there was marked swelling and deformity at the right ankle with considerable circulatory disturbance. The entire foot was cyanotic and the toes were quite cold. Roentgenograms revealed a trimalleolar fracture at the ankle with a displaced large posterior tibial fragment.

Due to impending gangrene of the foot he was given spinal anesthesia and a closed reduction was done. Fixation was obtained by a 7/64″ Steinmann pin drilled upward through the calcaneus and across the ankle joint. This seemed the best possible treatment due to the extreme swelling and circulatory deficit. The pin was removed two months later and a plaster walking boot was applied. Five weeks later it was taken off and physical therapy was started. This patient's progress was extremely gradual and nine months later he continued to have some disability. X-rays show the posterior fragment of the tibia to be healed in excellent position and the mortise of the ankle to be practically normal. Inversion and eversion are 50% of normal with flexion—extension 75% of normal range.

Comment

Case 1 was the first instance in which I used vertical pin fixation. This was indeed a last resort situation since the instability was quite marked and the deltoid ligament was frayed. Rather than make another incision at the distal fibula through this badly traumatized soft tissue it was thought best to insert a vertical pin which was done under direct vision across the ankle joint. The stability was excellent. Despite his size and the severity of his ankle injury he has obtained a complete functional recovery.

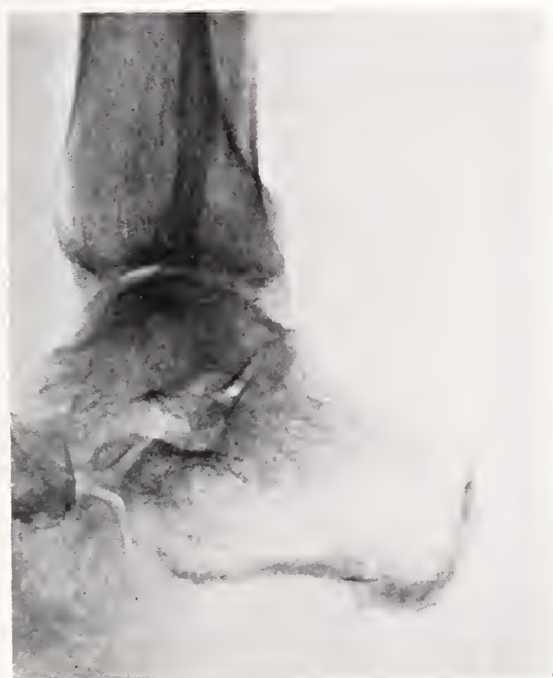
In Case 2 the potential complications, legal and otherwise, were obvious. Due to the 18 hours of applications of ice compresses combined with the dislocation at the ankle the de-



Case 2.: (left to right) The first picture shows the original deformity and the second two show the reduction in vertical pin fixation.

velopment of gangrene was certainly a possibility. The vertical pin was put in merely as a temporary measure until normal circulation had been established and then open reduction with screw fixation at the posterior malleolus had been planned.

The reduction, however, of the posterior tibial fragment was excellent following the pin fixation and it was decided to follow through without surgery. As yet, this patient does not have complete functional recovery but considering all circumstances a perfect result regardless of the type of treatment used would have been almost impossible. He is working regularly and it is hoped that he will make further progress. Considering the cold cyanotic foot and the long period of dislocation I believe the vertical pin offered the simplest and most efficient method of treatment available for this particular patient.



Case 2.: Lateral view showing complete healing of the posterior fragment six months after injury.

Summary and Conclusions

1. Pin and plaster fixation is an efficient method of treatment for certain ankle fractures.
2. A vertical pin and plaster boot procedure has been described which has received little medical attention. No reported cases of its usage in this country have been found.
3. The vertical pin procedure has the simplicity of closed reduction but gives the stability comparable to that obtained with open reduction and internal fixation. It should be reserved, in general, for those cases which cannot be treated in orthodox fashion.
4. No complications have occurred from its usage over a period of 18 months in nine patients.
5. This method of treatment has exceptional possibilities but is being designated as the "L.R." (last resort) treatment until more cases have been observed over longer periods of time.

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Probable Factors in Congenital Skin Defect

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It is thought that congenital skin defect is of hereditary origin and not related to Simonart bands. A bullous disorder in utero is quite improbable, although bullae were noticed in this case shortly after birth.

CONGENITAL skin defects of the newborn are rare anomalies that have been observed most frequently on the scalp,[1] but may occur elsewhere on the body. The lesions, which consist of varying degrees of loss of epidermis and/or subcutaneous tissue and fat, are generally round with sharp, punched-out margins, and measure from one to one and one-half inches in diameter.[2] Terruhn reviewed 76 cases in which the head was involved and 29 cases involving the rest of the body.[3]

There are two main theories as to the causation of such defects.[4] The first is that of heredity, more than one case having often been reported in the same family. With this disorder may be associated other neonatal anomalies: Hydrocephalus, menigocele, palatoschisis, cheilosis, coloboma, and microphthalmus. A case has been reported of bilateral congenital absence of the skin and subcutaneous tissue of the trunk associated with clubbing of the hands and feet.[6]

The second theory is that the lesions are due to adhesions between the amnion and fetal skin. When these adhesions, called Simonart's ligaments, are torn loose, a cutaneous defect remains. However, the fact that most such cutaneous lesions have a smooth border appears to discredit this theory. Most of the evidence presently available supports the theory of hereditary rather than physical factors.[6]

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Case Report

A one-day-old, three-pound white female, who was born in another city after seven and one-half hours of labor, was first seen on May 13, 1952. The mother vomited excessively throughout pregnancy. She threatened to abort at approximately four months, at which time bleeding occurred. There was no history of any skin difficulty or abnormality in the parents.

Physical Examination

There was absence of the skin of the scalp, ears, forearms, hands, abdomen and legs (Figures 1 and 2), but there was no secondary infection. The affected areas, which were yellow, were dry and the underlying blood vessels were visible. The skin of the tips of the fingers and toes appeared normal, and the fingernails and toenails were present and unaffected. The upper one-third of both ears and the left ear lobe

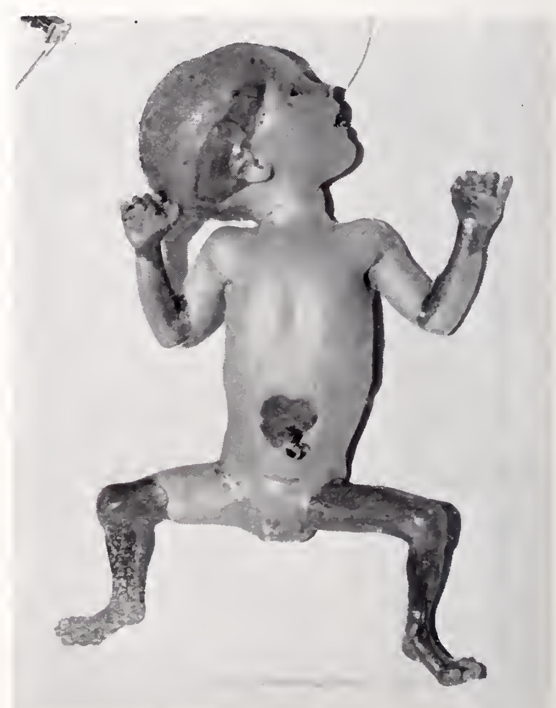

Figure 1: There is a loss of skin on the scalp, forearms and legs. The underlying blood vessels are visible.

Figure 2: The skin is absent over the scalp, hands, and legs.

appeared to be bound down to the scalp. There was hair across the posterior aspect of the scalp and nuchal area, but no hair was seen in the involved area of the scalp and there were no eyebrows. While diffusely scattered ronchi were present throughout both lungs, the remainder of the physical examination showed no abnormalities.

Course in Hospital

The patient was placed in an oxygen incubator and was given penicillin and streptomycin on the first day of hospitalization. The next day she was given glucose in water by polyethylene tube feeding, however, the course was steadily downhill; the skin became hard, firm, and rigid; two small bullae appeared over the trunk, and there was desquamation of the skin on the buttocks and pressure joints. The patient died on the second day of hospitalization, three days after birth.

At autopsy, gross examination showed no unusual findings beyond the skin lesions noted above. Anatomical dissection revealed that the left upper lobe of the lung and the right lung were solid and did not float when placed in water. There was some evidence of aeration in the other lobes of the lungs.

Microscopic examination of the involved areas showed the epidermis ended abruptly (Figure 3) and the corium was markedly reduced in thickness. Where the epidermis was absent, (Figure 4) there were no sebaceous glands, coil glands, or hair follicles.

Large areas of the lungs were not expanded but there was no evidence of pneumonic consolidation. The liver was diffusely congested and there were areas of hematopoiesis within the sinusoids. There were many eosinophiles within the peri-portal regions. The hepatic cells showed moderate fatty vacuolization.

The final pathological diagnosis was congenital skin defect, congestion of the liver with hematopoiesis and eosinophilic infiltration, and no expansion of two lobes of the lungs.

The patient showed large areas of loss of epidermis and corium. There were no apparent adhesions or tearing affect on the skin as would be present to support the theory of Simonart bands as an etiological factor. It is of interest that new bullae were noted after birth; development of bullae in utero is improbable.

It is not thought that there was etiological

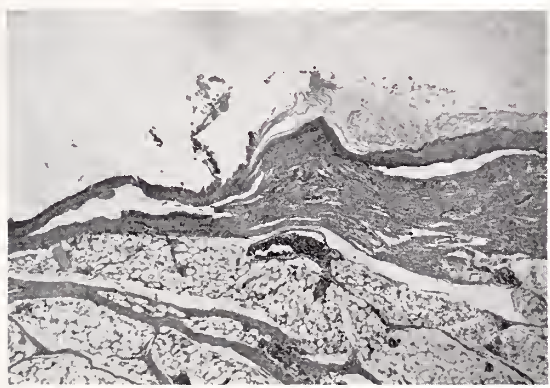

Figure 3: There is absence of epidermis and reduction in the corium in the involved area.

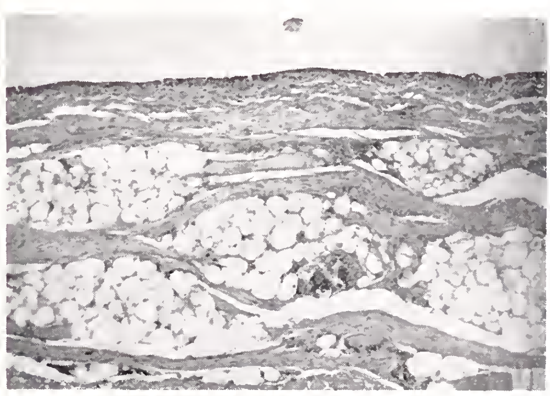

Figure 4: The corium is reduced and there are no sebaceous glands, coil glands, or hair follicles.

significance connected with the mother threatening to abort at four months pregnancy.

Summary

A case of extensive congenital skin defect is presented, with autopsy findings. There was loss of the entire epidermis and partial loss of the corium in the involved areas. There were no sebaceous glands or sweat glands in the affected areas. Two bullae appeared during the hospital course. Large areas of the lungs were not expanded.

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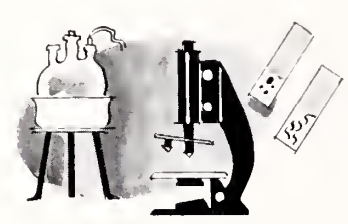

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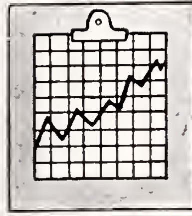
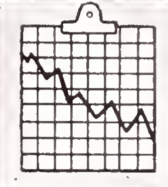


CASE DISCUSSIONS
From The University of Louisville Hospitals



Louisville General Hospital

Use of Local Anesthesia in Major Abdominal Surgery

James C. Drye, M.D.*

In recent years the employment of local anesthesia by general surgeons has become almost completely limited to its use in such minor procedures such as skin biopsy, lymph node biopsy, suture of minor lacerations and so forth. Many younger surgeons have never seen it used in such procedures as inguinal hernia repair, thyroidectomy, much less in major intra-abdominal procedures.

Surgeons of the older generations were many times forced to use local in such procedures because of the lack of developments in the field of general anesthesia and many were highly skilled in its use.

Local Anesthesia

Modern anesthesia has made such rapid strides in recent years that it has become pleasant, convenient and safe. However, we believe that there are still indications for the use of local anesthesia. First there are many relatively minor extra-abdominal procedures such as inguinal herniorrhaphy which lend themselves to local anesthesia. In many of these cases, I believe it is safer, and that the patients recover quickly and have less morbidity.

Secondly, we have found that we can perform major intra-abdominal lifesaving emergency procedures under local in the extreme bad risk patient whom we do not believe could tolerate even the most skillfully and perfectly administered general anesthesia. Examples of such procedures that we have performed are: repair of perforated duodenal ulcer, gastric resection for cancer (one case with five year survival), cholecystostomy, cholecystectomy, colostomy for obstruction and left colectomy.

If the patient is properly prepared, the local anesthesia properly administered and the surgery done in a gentle manner, such procedures can be performed adequately without pain and with increased safety to the patient. The complaints of the patient while on the operating room table are almost always related to such things as discomfort from lying still on a hard table, an elbow pressing against the rigid side of the table, the feet in an uncomfortable position and so forth.

If the patient is mentally competent, it is important to explain what he is to expect—that he will not be numb all over, that he will feel the drapes on his body and people touching him, but that his pain will be minimal and can be instantly controlled if he will tell the surgeon.

Preoperative Sedation

The preoperative sedation is given in somewhat heavier doses than is usually given for general anesthesia. We use a combination of barbiturates, meperidine hydrochloride, and atropine. A large strapping healthy man who is to undergo repair of inguinal hernia will receive about 75 mg. of meperidine hydrochloride, 3 grains of secobarbital, and 1/150 grain of atropine. On the other hand, the debilitated, poor risk, elderly patient will receive about 25 mg. of meperidine hydrochloride, 3/4 grain of secobarbital and no atropine. If the patient becomes restless and uncomfortable on the table, small additional doses may be administered, preferably intravenously.

The following case is an example of our use of local anesthesia in the critically ill, poor risk, elderly patient:

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Case Presentation

M.M., hospital #379490, an 83-year-old patient was admitted on January 7, 1963, with a chief complaint of jaundice. This woman had had a cholecystostomy in 1939. Following this she had relief for a period of about five years, and then again began to have repeated attacks of acute cholecystitis. She has been living in a nursing home for some years. The present illness had started about three weeks before admission, at which time the patient had developed abdominal pain, increasing jaundice, dark urine, and clay colored stools. The jaundice and pain apparently varied from time to time but did not disappear.

She was finally admitted to the Department of Surgery severely dehydrated, markedly jaundiced, with rather severe pain in the epigastrium. The temperature and blood count failed to show any evidence of active inflammation. The laboratory studies confirmed the impression of extrahepatic obstructive jaundice. X-rays showed a nonfunctioning gallbladder. The patient was a senile old lady who was a very poor historian. She had had a previous diagnosis of "chronic brain syndrome." Her cardiovascular renal systems were compatible with her age, and exhibited no particular pathology other than the changes accompanying senility.

Supportive Measures

She was treated for 10 days with the usual supportive measures, including naso-gastric suction, intervenous fluids and atropine. Her moderately disturbed electrolyte imbalance was corrected, the naso-gastric tube was removed after a few days and the patient put on a gallbladder diet. Ten days after admission we felt that she was in as good a condition as could be obtained and we decided to explore this woman's common duct and remove the gallbladder. Because of her senility and her general debility, it was thought that this should be done under local anesthesia.

Preoperative sedation consisted of 25 mg. of meperidine hydrochloride and a grain and a half of secobarbital.

The abdomen was prepped and draped in the usual manner. The local anesthetic solution used was 1% procaine with epinepherin added to make a concentration of 1-250,000. Four skin wheels were made just below the costal margin on each side. Using a 25 gauge 3 inch needle, a total of approximately 60 cc. of procaine were injected in the following manner. The needle was introduced through the skin and just beneath the fascia of the external oblique, beginning at a point at about the ninth or tenth rib, and the infiltration carried up to the xiphoid process, and then down the other side. About 5 to 10 cc. were injected directly into the rectus sheath, and then an intradermal injection was made in the midline of the abdomen along the line of the proposed incision.

Abdomen Opened

The abdomen was then opened through the midline incision. There was found a distended thickened gallbladder which contained stones. Exploration of the common duct revealed it to be dilated and stones were palpable in it. The common duct was opened, the stones removed, and the sphincter of Oddi gently dilated. The gallbladder was then removed in the usual manner, isolating and dividing the cystic duct and artery, and removing the gallbladder from its bed. The bed of the gallbladder was closed with 000 chromic catgut. A T-tube was placed into the common duct, drains placed in the pouch of Hartmann and the incision closed. During the course of the operation, the patient suffered little or no pain. At one time there was some discomfort when we were working in the area of the pedicle of the gallbladder, but this was very easily controlled by the injection of three or four cc. of the procaine solution into this area.

The patient was somewhat restless on the table, but it was apparent that this was due to the fact that she was lying on a hard table and at one time her arm was found to be pressing against the hard rigid edge of the table. The operation was completed in 45 minutes.

Postoperative Course

The patient ran an uncomplicated postoperative course, was back on a diet on the second day and the T-tube was removed on the 10th day in the surgical clinic. She was discharged from the hospital on the fifth day. The patient was last seen on February 4, approximately three weeks after operation. At that time, it was found that she had some minor wound

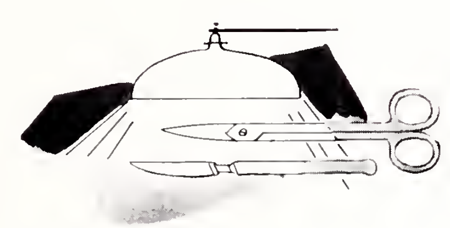
infection, but that she was getting along well. She was on a regular diet, having regular bowel movements, and had no complaints.

Discussion

This case is presented as an illustration as to what can be accomplished under local anesthesia. Bad risk patients are generally markedly debilitated, and have little muscle resistance. In addition it should be remembered that blockage of the intercostal nerves not only blocks sensation, but blocks the motor fibers as well. Relaxation is generally not a problem.

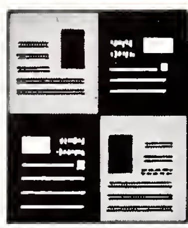
It is essential that such patients be informed before the procedure as to what is to happen to them, and to calm any apprehension. If the patient becomes apprehensive on the table and starts resisting, it increases the difficulty of the operation. However, this most always can be avoided.

In conclusion, we feel that local anesthesia is not employed as much as it should be. It is ideal for such minor procedures as herniorrhaphy. Further, in the bad risk, debilitated patient, we are sure that local anesthesia is a much safer procedure, the patients have less toxic reaction and recover more rapidly than they do when general anesthesia is used. Actually all anesthestic agents are toxic to some degree. It is interesting that the English anesthetists call themselves toxicologists, rather than pharmacologists. A long general anesthetic of whatever nature, necessitates administration of relative toxic drugs over a long period of time, and while people who are in a good condition can tolerate this very readily, it may be of critical importance in the old and debilitated patient.



Be Sure to Attend Your KSMA Trustee District Meeting

(See the story on page 256)



SPECIAL ARTICLES

"Strong Maladies Require Strong Medicine"*

GEORGE M. FISTER, M.D.
Ogden, Utah
President, American Medical Association

HIPPOCRATES, the great Greek physician, once said, "Strong maladies require strong medicine." These words have special meaning for the medical profession today.

One malady plaguing medicine is the slurs being voiced about our nation's unique system of medical care by those who have something else in mind for the people of America.

Some of the slurs, born of misunderstanding, can be forgiven. Others appear to have been deliberately conceived to discredit our medical care system and our profession.

Many of the disparaging remarks are half-truths being disseminated in the apparent hope that if repeated often enough they will insidiously eat away at free enterprise medicine as we know it today.

The symptoms are distressing in their potential impact on the welfare of the nation.

Strong Medicine Needed

The strong medicine needed to arrest this malady is to tell the people the truth about United States medicine . . . its past accomplishments, the breakthroughs just over the horizon, and the great vistas opening up to medical science.

The medical profession must play a major role in treating this malady. You and I must set the record straight—and keep it straight—by telling the true story of medicine as it is practiced in this country, and by telling what the few who are slurring our system are touting as a substitute.

In brief, we must diagnose the malady and treat it with truth.

Our medical care system never has been, nor should it ever be, exempt from constructive criticism. No one has claimed, nor should he claim, that it is perfect. While our system has known no peer in history, all of us are continuously working to make it better.

What about those who want to change our system? Are they advocating something better or something to correct the shortcomings of our present system? No. Strangely enough, they want to trade our present medical care system for bits and pieces of other systems that are alien to our traditions and history.

**Address to the American Medical Association House of Delegates at Los Angeles, Calif., November 26, 1962.*

The great edifice of American medicine has been built upon strong pillars. It has stood the test of time and it has kept pace with changing conditions. We must not let it be disfigured by the few who are chipping away at its foundations.

Today, medicine stands as a proud symbol of the finest achievements of our competitive enterprise system.

Our profession has helped to bring this nation the world's foremost record in medical care and progress. This has been accomplished by the efforts of the devoted members of the health team who have always doggedly resisted pressures to bring this dynamic system under the deadening anesthesia that federal control would bring to this program.

The progress of medicine in this nation is one of the most dramatic stories of the century.

Let's look at a few pages of the record:

Four and one-half million Americans are alive today who would be dead if the mortality rate of 25 years ago still prevailed. And these four and one-half million people earned almost ten and one-half billion dollars in 1960.

For the first time in our history, life expectancy for Americans has exceeded the Biblical three score and ten years, and it now stands at 70.2 years.

Eighty per cent of the drugs commonly prescribed today were unknown just 10 years ago.

The United States has made more important drug discoveries in the last two decades than all the rest of the world combined, or seven times as many as the next leading country.

Prescription Drug Industry

Just last year the prescription drug industry set a new record of $245,000,000 in research, an investment triple that of the average industry.

There now is a record number of hospital beds in this country — 1,670,000 an increase of more than 250,000 beds since 1948.

The average stay in a hospital is at its lowest in history.

During the year, infant mortality rates declined to the lowest in United States history, 25.3 deaths per 1,000 births.

A record number of 7,168 new physicians graduated from U. S. medical schools this year, and a record number of 31,078 students are enrolled in medical schools.

In 13 years this nation built 763 new hospitals, increasing the total number of hospitals to almost 7,000.

A record number of Americans, 136,000,000, is covered by voluntary health insurance and prepayment plans.

I could go on and on enumerating medical milestones.

These accomplishments did not "just happen." They came about because researchers, medical scientists, and physicians have had an opportunity to work in an atmosphere of freedom.

Achievement and freedom are not unrelated.

Free men have had the opportunity to develop this medical care system under a government and a constitution that encourage enterprise and industry. Men have been free to think, to work, to match their talents against the world.

This progress in medicine is having an increasingly profound effect upon the life of every citizen, every business and every institution in our country.

We all know that a healthy nation is a strong nation and at no time in our history has it been more vital that our nation be strong.

When I was a young man, I went abroad to London and Vienna to continue my medical education. Many American physicians went abroad to study in those days.

Foreign Students Come to U.S.

Today the reverse is true. Today physicians and medical students from foreign lands are coming to this country to study medicine under our great teachers. Right now there are nearly 9,000 foreign physicians and students studying medicine in the United States.

What more important commodity can this country export than to send these physicians home to their native lands with the broad medical knowledge learned in the medical classrooms and hospitals of America?

Through this program and through the medical missionary program, in which the American Medical Association is playing a vital role, United States medical know-how is finding its way into even the most remote areas of the world.

Hardly a day passes that from one to 25 foreign physicians and teachers do not visit the AMA headquarters in Chicago. They have come to learn more about our medicine.

American medicine can be proud of its contributions to international health.

I believe it also is interesting to note here that in the 10 years before 1948, the number of winners of the Nobel Prize in medicine between the United States and England was in balance—four for the United States and three for England. Since England adopted socialized medicine in 1948, American research has produced 19 Nobel Prize winners in medicine, while England has had but four.

Is it only coincidence that the decline in productive medical research in England followed the adoption of a system of rigid government control of all aspects of medical science?

It is important that the American people know the truth about this nation's medicine.

No segment of the United States' health team asks for any special honors. It seeks no special favors. It demands no special appreciation and acclamation. It desires only that the real story of progress and accomplishment be told so the people will not be misled by the critics who don't tell the whole story.

The health team's twin objectives are to win each and every daily struggle with sickness and injury and to reduce in the long run the number and severity of the cases it must face.

It is a fact that physicians, in effect, strive daily to reduce the need for their services.

It is a fact that the drug industry progresses only because it seeks to make its own products obsolete.

It is a fact that whole hospitals endeavor to provide the best kind of care and service, they labor to reduce the length of stay of the patient, now at its lowest in history.

It is a fact that the health insurance industry is interested in seeing that everyone is covered with the best possible protection at the lowest possible cost.

Today two-thirds of those who now are admitted to mental hospitals are discharged the first year. But 30 years ago a patient entering a mental hospital could expect to remain there up to 30 years or even the rest of his life.

Death rates of acute rheumatic fever and influenza are down about 85% since 1944.

Today one out of every three cancer patients survives whereas only one out of seven survived in 1937.

Only 40 years ago one in every four subject to a major operation died. Today only one in 100 dies and operations are performed now that were impossible only a few years ago.

And today the American people are getting more for their health care dollar than any time in history. They spend only six cents out of every dollar on health care. They spend almost as much on liquor and tobacco and three times as much on recreation and travel.

Better Medical Care

The people are getting far better medical care than any time in history and the cost of this care is in line with the cost of other services and commodities.

It is true that the average prescription cost is $3.21 today compared with the average cost of 91 cents in 1939. But the average wage earner works 18 minutes less today to buy this drug that has remarkable curative and preventive powers and will return him to good health quicker and safer than ever before.

This medical progress has given millions a chance to live when they might have died a few years ago. And the science of medicine is constantly progressing, always reaching upward toward the goal of a world free from the fear of serious illness.

As physicians we are eagerly awaiting the day of

organ transplants, greater cancer control, preventives for some types of heart disease, cures for multiple sclerosis and cerebral palsy, and new inroads against other killers and cripplers.

The Commission on the Cost of Medical Care will make its report next year, and I am sure that from its study will come a new and deeper insight into the complexity of the economics of medical care.

There are scores of other AMA projects and programs such as the drug information program, research grants, school health, public education, an accreditation program for postgraduate medical courses, and the Citizens Commission on Graduate Medical Education to study internship and residency programs.

This is an exciting period in the American Medical Association's history.

Membership at All-Time High

Today the Association's membership is at an all-time high of 193,639 physicians, and membership is growing at a faster rate than any time in history.

This growth in membership is due not only to the increased number of physicians but also to the outstanding scientific and socio-economic achievements of the Association and to the growing unity of the profession.

In my opinion the AMA-ERF Loan Fund is one of the greatest accomplishments in the history of the American Medical Association.

The medical profession and other members of the health team have made many noteworthy contributions toward providing the country with more trained physicians.

Physicians already have given more than $250,000 to the AMA-ERF loan program.

Every year thousands of doctors contribute more than 250 million dollars in time to teaching in our medical schools.

In addition, physicians contribute annually approximately five million dollars to the AMA-ERF and to their own medical schools. Most of these funds can be used by the medical school deans as they see fit.

The AMA also has an effective nationwide medical careers information program in high schools, colleges and communities to attract superior students.

More than 300 inquiries from students interested in medical careers are received at AMA headquarters every week, and between 15,000 and 20,000 packets of information are sent out to these students a year.

Since the end of World War II, nine new medical schools have been opened. Five more new medical schools will be established in the near future, and there is a possibility that an additional six will be announced before too long.

Yes, we must tell the people the truth about American medicine.

The AMA House of Delegates has restated time and again that the medical profession guarantees physician services to all regardless of ability to pay. This is our way of taking care of all those who need our services.

Hundreds of county medical societies have purchased advertising space in their local newspapers to inform the citizens that no one need go without physician services because of the lack of funds.

Surveys show that the medical profession annually gives more than $700,000,000 in free medical care.

Most of us thought when we graduated from medical school and entered practice that if we practiced good medicine, if we kept pace with the advances in medical science, and if we were dedicated and devoted to preserving and prolonging life, to alleviating suffering and pain, to conquering disease, then we would have fulfilled our responsibilities to the public.

That may have been enough to give a few years ago, but it isn't enough today.

Today we must tell the true story of American medicine to the people. We cannot stand by and permit a few to defame the medical care system that has had such a profound effect on the lives of so many.

All of you will recall that when we began to tell the people about the "fine print" in the King-Anderson Bill, the Gallup Poll reported that 67% of the people favored that proposal. But as the physicians presented the facts to the people, the Poll's statistics began to change. As the people became better acquainted with the issue, support for King-Anderson fell to 55%, then to 48% and then to 44% before the Senate vote was taken.

The people, through their elected representatives, will make the right decisions when they know all of the facts.

A final word of caution — let us not permit ourselves as a profession to compromise our basic principles. Nor should we endanger our position — as set forth by this House of Delegates—by the adoption of policy statements which commit the profession to a course of action that could be intentionally or unintentionally misinterpreted and generate serious misunderstanding on the part of the public.

No Substitute for Freedom

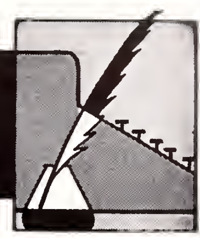
We cannot give ground on basic principles. There is no substitute for freedom in medical practice, and there never will be. There is no substitute for the private relationship of patient and physician, and there never will be. There is no substitute for voluntarism, and there never will be.

All of us are aware that medicine once again faces an extremely critical period in which the Administration will direct its massive power toward an attempt to force through Congress another health care for the aged bill financed through Social Security. I am confident that we can again win this struggle. But victory will require calm, intelligent, well-reasoned action on the part of the entire profession.

We will not compromise on the fundamental principles in which we believe and for which we have fought in the past with courage and good judgment. We will not jeopardize our position either by indicating a willingness to consider a compromise which would damage our basic principles, or by hasty action which might be misinterpreted.

(Continued on Page 275)

EDITORIALS



Continuing Medical Education

IN the January KAGP Journal the President, J. Sankey Williams, M.D., has written a very comprehensive and enlightening page concerning the philosophy and objectives of his organization. He characterizes the American Academy of General Practice as the youngest organized sector of medicine as well as its largest. The Academy came into being for the primary purpose of elevating the quality of medical care. This has required the improvement of the professional ability of the members.

During the past 10 years the Kentucky Academy of General Practice has been most active and diligent in promoting postgraduate training for the members and has invited all physicians to attend their excellent seminars. Leading teachers, researchers and practitioners from all specialties and from all over the United States have appeared on their programs. The seminars have been held in widely separated areas over the State in order to bring to the members, in their own communities, the opportunity for improvement.

It requires no effort to believe Doctor Williams' thesis that the primary purpose of his organization is the improvement of the professional ability of its members—to preserve their right to practice in freedom from regimented control—to further elevate our standard of medical care for the people. These are high objectives indeed which all physicians in whatever field should strive to attain.

In the same Journal Robert M. Sirkle, M.D., secretary, has deplored the trend of Academy members to show some decline in interest and attendance upon these excellent courses and seminars which have been so well and thoroughly planned. One wise requirement for membership in the Academy is maintenance annually of a minimum number of Category I hours of postgraduate training. With the most diligent planning and an increasingly attractive array of teaching talent, there has been some lagging of interest and loss of members. This is discouraging.

According to American Medical Association Compilations there were 265,406 physicians in the United States on July 2, 1962: Of these 177,889 were engaged in private practice. There were 56,759 general practitioners of whom 55,821 were engaged in private practice. In Kentucky, of 2,172 physicians engaged in private practice 897 are listed as general practitioners. These figures are only approximate. Compilations in our own KSMA office are at some variance but not significantly so for the purpose of this discussion. It remains true that general practitioners constitute the largest proportion of physicians; about one-third in the United States and more than that in Kentucky. The policies and plans of their organization vitally affect the trend of the quality of medical care of all.

The same increased interest in postgraduate training has been apparent in all fields of limited practice since World War II. Specialized organizations such as the Academy of Pediatries, The College of Surgeons, The College of Physicians have continued their annual national conventions but have promoted regional and sectional meetings where a much larger proportion of the members may attend and participate in the programs.

More recently medical school deans and faculties have accepted the challenge to extend their clinics and seminars to localities in their areas. It is a good thing to bring our teachers and researchers into closer and personal contact with practicing physicians. In return our county and district societies have invited and urged faculty men to participate more freely in their activities and to help in the problems continually confronting them. A closer and

more cordial relationship is thus cultivated. It proves stimulating to us all.

The medical profession cannot afford to be divided between teachers, researchers and clinicians, between general practitioners and specialists, between old and young—we would do well to move together, to be a united profession. It should make little difference whom the patient elects to call when he is ill so long as he is eventually offered the best that our complex system of medical facilities and personnel has to offer. The present increased tempo and dispersion of continuing medical education should prove highly beneficial to us all. But as Doctor Sirkle has said it will profit us little if we neglect to share in the scientific and intellectual fare that these days is so abundantly supplied and so widely dispersed.

Sam A. Overstreet, M.D.

"See You in Atlantic City"

THE American Medical Association will hold its 112th annual meeting June 16-20 at Atlantic City. In urging you to attend, I would like to write briefly about an aspect of science that is rapidly becoming a very serious problem. I refer to what scientists have called "The Publication Explosion".

Research men are faced with the dictum of "publish or perish". Naturally, they publish. They publish so much that some areas of science now have such a volume of literature that it is often cheaper and faster to repeat an experiment than to search the literature and find out what others have done in the same field.

It has been said that it would be necessary for a physician to read one book an hour just to keep up with new findings in his own specialty. This obviously is impossible.

There were 4,000,000 scientific documents published in 1962. These included some 3,000,000 papers and articles in some 70,000 technical and professional journals. The bulk of these are in the life sciences, particularly medicine. They are published in at least 65 different languages, in almost every country of consequence in the world.

Faced with this overwhelming deluge of paper, the physician in practice, already one of the busiest men in his community, may be inclined to just throw up his hands.

The scientific meeting helps greatly to fill the gap and to help the physician keep abreast of new developments. At the AMA annual meeting, in a short space of four or five days, the physician has his choice of literally hundreds of scientific papers covering the broad spectrum of medicine. He can select half a dozen lectures daily from the program as a whole. Or he can concentrate on his specialty section and its meetings.

The physician can select outstanding medical motion pictures, fresh from the production line. Or he can view live telecasts of surgery and medicine in action in new areas.

It would take years of reading an hour a day to learn all that can be learned in five days at the annual meeting of the AMA. The scientific exhibits alone are a good postgraduate course in medicine.

All of us as physicians are well aware of the problems of keeping abreast, of bringing the findings of the researchers into our practice as soon as possible. Through the annual meeting of our national association we can make considerable progress in this important respect.

As president of the AMA, I personally urge every American physician to make plans now to attend this annual meeting June 16-20 in Atlantic City.

George M. Fister, M.D.
President, AMA

The Job Should Seek the Man —

Some of Them Young

AN INFORMED, courageous and experienced leadership within our profession at all levels is the principal ingredient for the successful operation of the county, state or American Medical Association.

Training and developing leadership to help guide the course of medicine in these difficult times and in the future is a matter of major concern to all of us in the profession. This is obviously a question of prime importance.

The foresight of the Board of Trustees of KSMA in undertaking a policy that is intended to help accomplish these ends should be applauded by every one of us. Beginning with the new '62-'63 Associational year, the Board of Trustees undertook to limit the committee appointments any member might hold to one. There are a few exceptions to this where by reason of a man's position as chairman of a committee, he is automatically a member of the council of that committee.

In reviewing the records prior to this Associational year, it was found that some of our members were holding up to four or five committee appointments while other talented younger members who should be brought into the organization were left without responsibilities.

We all know that there is a tendency for the job to seek a good man. This is as it should be. It is natural to call on the man you know will deliver. This is why too many good men had multiple committee assignments. However, in the long run, this can work a hardship on the welfare of the Association as well as the individual, since it limits the development of new members and retards the progress of the Association.

Certainly those of us who have spent these many years in organized medicine should welcome this new policy and do all that we can to support our Board of Trustees in its efforts to guarantee the best leadership for our Association in the future.

KSMA Senior Day

March 18

Medical Arts Building, Louisville

Afternoon Session—2:30 P.M.

Evening Session—6:15 P.M.

All KSMA Members Are Invited

ORGANIZATION SECTION

Five KSMA Trustee Districts Schedule Meetings

Five Trustee Districts of the Kentucky State Medical Association have scheduled meetings for March and April. They are the Fifth, 11th, 12th, 14th and 15th.

Trustee Districts which have already held meetings in 1963 are the First, Sixth, Seventh, Eighth and 13th. There was a total attendance of 323 at these first five district meetings.

On March 14, the 11th District, for whom the trustee is Hubert C. Jones, M.D., Berea, will meet at the Richmond Country Club, Richmond, Ky. David M. Cox, M.D., Louisville, president of KSMA, and Hoyt D. Gardner, M.D., Louisville, will speak. Doctor Cox will address the group on "You, the KSMA and the Patient." Doctor Gardner will speak on "Vote Now or Pay Later."

The 12th and 15th Districts will hold a joint meeting March 28 at Cumberland Falls State Park. Speakers will be Doctor Cox and Doctor Gardner. Doctor Cox will discuss "Your Profession and You." Doctor Gardner's topic will be "Vote Now or Pay Later."

Thomas O. Meredith, M.D., Harrodsburg, is trustee for the 12th District and Keith P. Smith, M.D., Corbin, is trustee for the 15th District.

On March 28, the 14th Trustee District will meet at Jenny Wiley State Park near Prestonsburg, with William C. Hambley, M.D., Pikeville, trustee, presiding.

Speakers will be Henry B. Asman, M.D., and Robert W. Lykins, M.D., both of Louisville. Doctor Asman will have as his subject: "Medical Legislation and Survival," and Doctor Lykins." KEMPAC—Politically the Chips Are Down."

April 15 is the date selected for the meeting of the Fifth Trustee District. Trustee is Carlisle Morse, M.D., Louisville.

Speakers at the Fifth District Trustee meeting will be Mayor William O. Cowger of Louisville and K. P. Vinsel, executive secretary of the Louisville Chamber of Commerce. Mayor Cowger will speak on the topic: "Importance of KEMPAC and the Political Action of Doctors," and Mr. Vinsel on "Economic and Political Horizons—1970."

Doctors Cox and Gardner addressed the meeting of the Seventh Trustee District at Frankfort February 21. Donald Chatham, M.D., Shelbyville, is Seventh District trustee.

John P. Glenn, M.D., trustee for the Sixth District, opened the meeting of that District at Franklin February 12. Speakers were: John C. Quertermous, M.D., Murray, and Doctor Gardner.

Public Health and Medical C and B Defense Course Offered

A six-day training course in chemical and biological defense is currently being offered once a month at Fort McClellan, Ala., by the United States Public Health Service, Division of Health Mobilization.

The course, which will be repeated through June, is conducted in cooperation with the Army Chemical Corps School, Fort McClellan, and is designed to train public health and medical personnel in developing chemical and biological defense programs within States, counties, and principal municipalities.

The course includes detailed instruction in the following subject areas: Public health aspects of chemical and biological warfare; detection, identification, and current capabilities of chemical and biological agents; survey and delineation of contaminated areas; decontamination materials and techniques; first aid and treatment for chemical and biological casualties; care and use of defensive equipment; psychological aspects of chemical and biological weapons systems.

There is no tuition fee nor is security clearance required. Future courses are scheduled to begin March 25, April 22, May 13, and June 17.

Requests for application forms and further information should be addressed to: Kentucky State Medical Association, 3532 Janet Avenue, Louisville 5, Kentucky, Attn.: Secretary, Emergency Medical Services Committee.

ARC Names 5 Kentucky MDs.

Robert H. Akers, M.D.; H. Laveine Townsend, M.D., and James B. Douglas, M.D. — all of Louisville; Harold D. Rosenbaum, M.D., Lexington, and John L. Dixon, M.D., Owensboro, were among more than 60 radiologists named Fellows of the American College of Radiology at the annual meeting of the College at Chicago, February 8.

Doctors Akers and Dixon are graduates of the University of Louisville School of Medicine; Doctor Rosenbaum is a graduate of Harvard Medical School; Doctor Douglas, the University of Michigan School of Medicine, and Doctor Townsend is a graduate of Washington University Medical School.

Senior Day Is March 18

Senior Day, sponsored by the Kentucky State Medical Association in cooperation with the University of Louisville School of Medicine and the Jefferson County Medical Society, will be March 18. For a complete program see the February issue of The Journal, page 157. All KSMA members are invited to attend.

Ky. Chapter, College of Surgeons Plans Instructive Session

Plans for an instructive and outstanding two-day program have been made for the annual meeting of the Kentucky Chapter of the American College of Surgeons. The sessions will be held at the Brown Hotel, Louisville, Ky., March 29-30.

Guest speaker at both the Friday afternoon and Saturday morning sessions will be Barton McSwain, M.D., Nashville, Tenn., professor of surgery, Vanderbilt University School of Medicine. Doctor McSwain was graduated from the Vanderbilt Medical School in 1930. He taught at Cornell Medical College before entering military service as a lieutenant commander in the Medical Corps, USNR in 1944. In 1946, upon being separated from the service, he joined the faculty at Vanderbilt. He is visiting surgeon, OPD, at Vanderbilt University Hospital and consultant in oncology at Veterans Administration Hospital at Nashville.

Doctor McSwain

Highlights of the program are as follows:

The Friday morning session, March 29, will be presented by the Department of Surgery, University of Louisville School of Medicine, with Rudolph J. Noer, M.D., as chairman.

Speakers and their subjects are as follows: John S. Harter, M.D., "Biological Approach to Cancer Therapy"; Charles K. Sergeant, M.D., "Wilm's Tumor"; E. Truman Mays, M.D., and Raul C. Gonzales, M.D., "Axygograms"; Herbert Ransdell, Jr., M.D., "Treatment of Flail Chest with the Piston Respirator"; Berel L. Abrams, M.D., "Volvulus of the Sigmoid Colon"; Joseph E. Kutz, M.D., "Ulnar Nerve Compression Syndrome"; Doctor Noer, "Thoracic Trauma." Clyde C. Sparks, M.D., Ashland president of the Kentucky Chapter, will preside at the morning session which will be followed by a fellowship luncheon with Doctor McSwain and James H. Spencer, M.D., representative of the American College of Surgeons, as guests of honor.

Delmas M. Clardy, M.D., Hopkinsville, vice president of the Chapter, will preside over the Friday afternoon session. David A. Hull, M.D., and Gordon Hyde, M.D., Lexington, will speak on "Selective Vagotomy," and Doctor McSwain will discuss "Carcinoma of the Colon, Rectum and Anus."

A panel discussion on "Intensive Patient Care" will follow moderated by William T. Rumage, M.D., Louisville. Participants will be: Howard Boast, Ph.D., Lexington, administrator, University of Kentucky Medical Center; Joseph E. Hamilton, M.D., Louisville, chief of surgical service, Veterans Administration Hospital, and Doctor Spencer.

A cocktail party and dinner will take place Friday evening. Doctor Sparks will be master of ceremonies. Guest dinner speaker will be Henry M. Johnson, Ph.D., D.D., Fort Worth, Tex., who will discuss "How to be Happy—Although Married".

Doctor Clardy will preside at the Saturday morning session. Speakers and their subjects will be:

Henry I. Berman, M.D., Louisville, "Urinary Tract Dysfunction Complicating Abdominal-Perineal Resection"; George B. Sanders, M.D., Louisville, "Gas Gangrene of the Abdominal Wall"; Jere C. Robertson, M.D., Hopkinsville, "Management of Pelvic Relaxation During Laparotomy"; Rene Menguy, M.D., and Y. F. Masters, B.S., Lexington, "Effect of Cortisone on the Secretion of Mucoprotein by the Gastric Antrum of Dogs. Pathogenesis of Steroid Ulcer"; Giles Stephens, M.D., Louisville, "Pilonidal Sinus—Its Excision and Primary Closure in 393 Cases and Follow-Up of 3-14 Years".

"The Rise and Possible Decline of Surgery" will be Doctor McSwain's subject.

Final item on the agenda will be a business meeting of the Chapter.

Members Urged To Cooperate With County Society Secretary

Membership in the Kentucky State Medical Association and the American Medical Association is at an all-time high says KSMA President David M. Cox, M.D., Louisville. This statement was made when Doctor Cox urged those who had not remitted their dues to their local county medical society secretaries to kindly do so at their earliest convenience.

Doctor Cox pointed out that the county society secretary is busy like all other physicians looking after his individual practice and that the best interests of all were served by working with the county medical society secretary in this situation.

Doctor Cox complimented the secretaries and the members, in behalf of the Board of Trustees and himself, for the large and early response of the members who have already paid their county, state and AMA dues.

Section 2, Chapter VIII of the Bylaws states that the deadline for the payment of dues is the first day of April.

New Session Plan Will Improve 1963 KSMA Annual Meeting

Scheduling the first session of the House of Delegates at the Kentucky State Medical Association's 1963 Annual Meeting for 9 a.m. September 23 will allow the Reference Committees to meet at 2 p.m. that day and avoid competition of committee sessions with the scientific program which begins the following day, according to Garnett J. Sweeney, M.D., Liberty, speaker of the House.

Scientific sessions along with meetings of cooperating specialty groups will begin September 24 and run through September 26 at the 1963 KSMA Annual Meeting, which will be at the Phoenix Hotel, Lexington.

Reports and resolutions will be introduced at the September 23 morning session of the House of Delegates. The Reference Committees, meeting that afternoon before the start of the scientific sessions, will

have more time to consider and draw up their reports. The second session of the House will be Wednesday afternoon, September 25.

Doctor Sweeney also pointed out that moving the House of Delegates' first session to a morning hour will provide delegates a free evening, heretofore taken up with the business meeting.

KAGP Plans Annual Session

A panel symposium discussing "Cleft Lip and Cleft Palate Problems" will be featured at the Wednesday afternoon session of the annual meeting of the Kentucky Academy of General Practice, May 8-10, at the Kentucky Hotel, Louisville. J. Sankey Williams, M.D., Nicholasville, is KAGP president and Harry U. Whayne, M.D., Murray, president-elect, is scheduled to be advanced to the presidency during the annual meeting.

There will be a dinner and entertainment Thursday evening.

A full program, which at this writing is in the planning stage, will be carried in the April issue of The Journal.

Prominent Speakers to Address Ky. Ob.-Gyn. Society

Outstanding authorities from outside the State and from Kentucky will be featured speakers at the annual meeting of the Kentucky Obstetrical and Gynecological Society, May 9-10 at Lexington, George G. Greene, M.D., Lexington, president of the Society, has announced.

E. C. Hamblen, M.D., Duke University, Durham, N.C.; Buford Word, M.D., University of Alabama, Birmingham, and Robert Hingson, M.D., Western Reserve University, Cleveland, Ohio, are to address the meeting. Among Kentucky speakers will be: Harold Kosasky, M.D., University of Louisville; Robert Griffin, M.D., Lexington, and John M. Baird, M.D., Danville.

There will be one or more panel discussions with chairmen of the Departments of Obstetrics and Gynecology of the University of Louisville and the University of Kentucky participating. A complete program will be in the April issue of The Journal.

Ky. Surgical Society To Meet May 17-18 at Lexington

The Kentucky Surgical Society will meet May 17-18 at the University of Kentucky Medical Center at Lexington, according to an announcement by Blaine Lewis, M.D., Louisville, secretary-treasurer of the Society. Headquarters hotel for the meeting will be the Campbell House.

Benjamin Eiseman, M.D., and Frank Spencer, M.D., of the Medical Center will be in charge of Friday's program and members of the Society will conduct the Saturday session. Guest speaker at the Saturday session will be Bernard Zimmerman, M.D.

A style show and luncheon are planned for the ladies on Friday afternoon and a dinner and dance will be held Friday evening.

Blue Cross-Blue Shield Returns To Insured Are Highest

COMPANY	EARNED PREMIUMS*	LOSSES INCURRED*	LOSS RATIO (%)
ALL Blue Cross-Blue Shield PLANS From Reports Submitted	2,931	2,689	92
Metropolitan Life	480	390	81
Aetna Life	385	343	89
The Travelers	356	307	86
Prudential	320	237	74
Mutual of Omaha	246	165	67
Equitable Society	245	209	85
Continental Casualty	199	129	65
Connecticut General Life	135	116	86
Bankers Life & Casualty	128	76	60
John Hancock	108	89	83
Occidental Life of Calif.	98	85	87
Provident L & A	88	74	84
New York Life	81	59	73
Lincoln National Life	56	45	80
Washington National	54	34	63
Continental Assurance	53	45	86
Reserve Life of Dallas	52	31	59
United of Am.	51	19	37
Pacific Mutual Life	44	37	84
Liberty Mutual	43	39	90
Union Labor Life	42	38	91
Combined Ins. Co. of Am.	36	13	35
General Am. Life	34	27	81
Paul Revere Life	31	18	57
Business Men's Assurance	29	20	69
Benefit Assn. Railway Emp's.	29	22	76
Monarch Life	29	16	54
Great - West Life Assurance	28	22	79
Bankers Life of Iowa	28	22	79
National Casualty	27	17	63
Mass. Mutual Life	27	23	84
KENTUCKY BLUE CROSS - SHIELD	26	24	92
Hartford A & I	22	16	70
Republic Nat. Life of Dallas	22	19	90
American Casualty	21	14	67
Zurich Insurance Company	18	14	78
Lumberman's Mutual Casualty	18	13	71
State Mutual Life	17	13	73
North American Accident	16	11	66
Union Mutual Life	15	10.6	73
United States Life	14	10.5	77
Mass. Protective	12	5.8	49
Life of Va.	12	8.3	70
World Ins. of Omaha	11	5.4	49
Federal L & C	11	6.4	59
Woodmen A & L	11	6.9	61
Inter-Ocean	9.7	5.3	55
Royal - Globe Ins. Group	9.3	6.6	71
Mass. Indemnity & Life	9.1	3.5	39
Loyal Protective Life	7.6	3.9	51
Commercial Travelers	7.2	5.3	73
Craftsmen	5.0	2.6	54
Am. Progressive Health	3.9	1.7	43
Security Mutual Life	3.4	3.2	60
National Accident & Health	2.5	.98	38
American Income Life	2.1	1.0	47

*(In Millions of Dollars)
From the Argus Chart, 1962.

Kentucky Blue Cross-Blue Shield return a greater part of premiums collected to their subscribers than do any of the other 56 leading companies for accident and health and hospitalization insurance in the Commonwealth.

The experience of the companies considered is from the Argus chart for 1962 which is a standard publication giving operational data for the insurance industry.

The following table shows the amount of premiums collected, losses incurred and the per cent returned to patients of the premiums collected.

Ky. Hospital Association Plans April 1-4 Meeting

"Kentucky and Its Hospital Program" will be the subject of the address by Kentucky Governor Bert T. Combs at the opening session of the 34th annual meeting of the Kentucky Hospital Association at the Kentucky Hotel, Louisville, April 1-4. Louisville Mayor William O. Cowger will also address the opening session. Presiding will be Otis L. Wheeler, director of Jewish Hospital, Louisville, president-elect of the Association.

Tuesday afternoon there will be seminar sessions on the following topics: "Personnel Relations," "The Intensive Care Unit" and "Public Relations." Robert E. Selwyn, Harlan, administrator of Harlan Memorial Hospital, president of KHA will preside at the Wednesday morning general assembly. Subject for a debate on the program will be "Hospitals and the Law." Participants will be Charles E. Gaines and Martin J. Duffy, Jr.

Miss Elizabeth Mudge will address the Wednesday afternoon session on "Explain Costs to Hospital Patients." Clarence N. Walker will address the Wednesday evening banquet session on "Keys to Health, Wealth and Happiness."

New Physician-Clergy Feature Planned for AMA Meeting

A new feature, "Physician and Clergy Meet in Patient Care," is planned for the 112th annual meeting of the American Medical Association, Atlantic City, June 16-20, according to Milford O. Rouse, M.D., Dallas, chairman of the AMA Committee on Medicine and Religion.

"The ill person is often more than physically ill. He is — at least to a degree — also mentally, spiritually and socially ill. Therefore, these four aspects should be considered in treating him," Doctor Rouse said.

The Rev. Doctor Paul B. McCleave, Chicago, director of the AMA Department of Medicine and Religion, said the program results from the mutual exchange of information between physicians and the clergy at the local medical society level. He anticipates that 3,000 will attend the medicine-religion program.

More than 200 top U. S. scientists will present new and original papers at the multiple discipline research forum at the AMA annual meeting. There will be eight general scientific sessions dealing with strokes, genetics, cancer chemotherapy, peptic ulcer, myocardial infarction, painful back, obesity and venereal disease.

Some of the highlights of the scientific programs sponsored by sections of the AMA include: *Dermatology:* perioral dermatitis, purpura caused by Carbromal, mole cancer in vaccination scars, detection of retinal damage from anti-malarial drugs. *General practice:* hemoptysis, cardiac arrhythmias.

Physical medicine: stroke, painful back, physical fitness, lymphedema. *Preventive medicine:* obesity. *Nervous and mental diseases:* magnesium deficiency, stereotaxic surgery, Contemporary Conversion Reactions III, placebo effect, behavior mechanism, neuropharmacology, childhood schizophrenia, peripheral neuritides, steroids in demyelinating disease, head injuries, convulsive disorders.

Pathology and physiology: fatalities from toxic substances. Rudolph J. Muelling, Jr., M.D., University of Kentucky Medical Center, Lexington, will be a speaker.

Anesthesiology: anesthesia by sustained hydration, topical anesthesia, anesthesia for extracardiac surgery in pediatric patients with congenital heart disease. *Ophthalmology:* vessels of the fundus of the eye, arteriole circulation of the brain, internal carotid artery and its branches, basilar arteries, aneurysms at the Circle of Willis, aortic arch syndrome.

Doctor Pierce Moderates Chicago AMA Panel

The third National Congress on Voluntary Health Insurance and Prepayment was held in Chicago, February 15-16. The program was sponsored by the American Medical Association Council on Medical Service.

W. Vinson Pierce, M.D., Covington, was moderator of a panel conducted Friday morning, February 15, on the "Accomplishments of Yesterday". Doctor Pierce is chairman of KSMA's Advisory Commission to Blue Shield, member of KSMA's Council on Medical Service, and a member of AMA's Insurance Committee. In his opening remarks, Doctor Pierce stated that "Our people have the finest health care in the world, and this has been accomplished through the voluntary system—the American Way".

The meeting closed Saturday noon with an outstanding address by Edward R. Annis, M.D., president-elect, American Medical Association.

Symposium on Premature Infant Slated for April 4

The pediatric department of the Good Samaritan Hospital, Cincinnati, will hold a symposium on certain aspects of the care of the premature infant from 1 to 5:30 p.m. April 4 in the auditorium of the hospital.

James Sutherland, M.D., associate professor of pediatrics at the University of Cincinnati, will speak on "Resuscitation of the Newborn"; Heinz Eichenwald, M.D., professor of pediatrics, Cornell Medical Center, will have as his subject, "The Diagnosis and Treatment of Infections in the Premature," and Mary Ellen Avery, M.D., associate professor of pediatrics, Johns Hopkins Hospital, "The Current Concepts as to the Etiology and Treatment of the Respiratory Distress Syndrome."

Donald Frank, M.D., is in charge of arrangements.

Rural Health Conference Oct. 24

The 11th annual Kentucky Rural Health Conference will be held October 24 at the University of Kentucky Medical Center, Lexington, according to an announcement by James C. Salato, M.D., Columbia, chairman of the Kentucky Rural Health Council.

New IRS Travel and Entertainment Expense Regulations—Explained from Physicians' Point of View

(This article has important tax information for every Kentucky State Medical Association member. It was prepared especially for The Journal by the Federal Tax Committee of the Kentucky Society of Certified Public Accountants, of which Joseph H. Keller, C.P.A., Louisville, Ky., is chairman. It has been written with the physician's tax problems in mind, and relates specifically to the new Internal Revenue Service regulations on travel and entertainment expense reporting and deductions.)

THE REVENUE Act of 1962 applies new restrictions on deductions for entertainment, entertainment facilities, travel and business gifts. These new rules apply to expenses incurred after January 1, 1963. In the past the taxpayer was allowed an *estimated* amount when unable to completely substantiate deductible expenditures. This is no longer possible.

Entertainment is one expense frequently incurred by a professional man. The new rules have limited the type of entertainment expense and the conditions under which it will be deductible. You will have to substantiate entertainment expenses by showing:

1. That the entertainment is *directly related* to the active conduct of your profession
2. That the entertainment precedes or follows a *substantial and bona fide business discussion associated with* the active conduct of your profession

In connection with "*directly related*" the taxpayer will be expected to show more than a general expectation of deriving income at some indefinite future time, however, he will not be expected to show that income actually resulted from each expenditure for which a deduction is claimed. The person entertained must have a direct relationship to the business of the taxpayer and entertaining must be in a place conducive to conducting business or carrying on discussions.

Business does not need to be transacted during the entertainment as long as a *substantial and bona fide business discussion* took place before or after the entertainment. The associated *with* test will sometimes allow a deduction for the cost of entertainment of business associates and their wives, even though the wives did not participate in the discussion. The expenses of attending business meetings, conventions, and trade associations will normally be deductible for the taxpayer, but the extra cost for the wife cannot be charged to Uncle Sam.

In connection with the deductibility of entertainment facilities (country club dues, automobiles, airplanes, hunting lodges, etc.) a record of both business and non-business use of the facility must be maintained. To deduct any portion of the expense the facility must be used primarily (more than 50%) for the furtherance of the taxpayer's profession. If the facility is not used more than 50% for business purposes no portion of the expense is deductible. However, dues paid to professional and community organizations are deductible.

Travel expenses related to your professional work are deductible. The cost of transportation on trips combining business with pleasure must be allocated between each activity unless the total time away does not exceed one week or the time spent for personal reasons constitutes less than 25% of the total time away from home.

In connection with your travel expenses, it should be remembered that the same important detailed record keeping requirement and support of disbursements apply even though these amounts are reimbursed to you when traveling for your medical association or for an employer.

In conclusion, you should review these matters very carefully, as they apply to you, with your income tax adviser, perhaps when he reviews your 1962 tax records.

Dr. Gardner Heads U. of L. Alumni

Hoyt D. Gardner, M.D., is the new president of the University of Louisville Medical Alumni. Other new officers elected are: vice president, William P. VonderHaar, M.D., and secretary-treasurer, Lonnie W. Howerton, Jr., M.D. Named to the board of directors were: Frank M. Gaines, Jr., M.D., and Charles G. Bryant, M.D. J. Thomas Giannini, M.D., is the immediate past president. All are from Louisville.

The Alumni will hold their annual senior banquet in May and are planning a get-together at the KSMA Annual Meeting in Lexington in September.

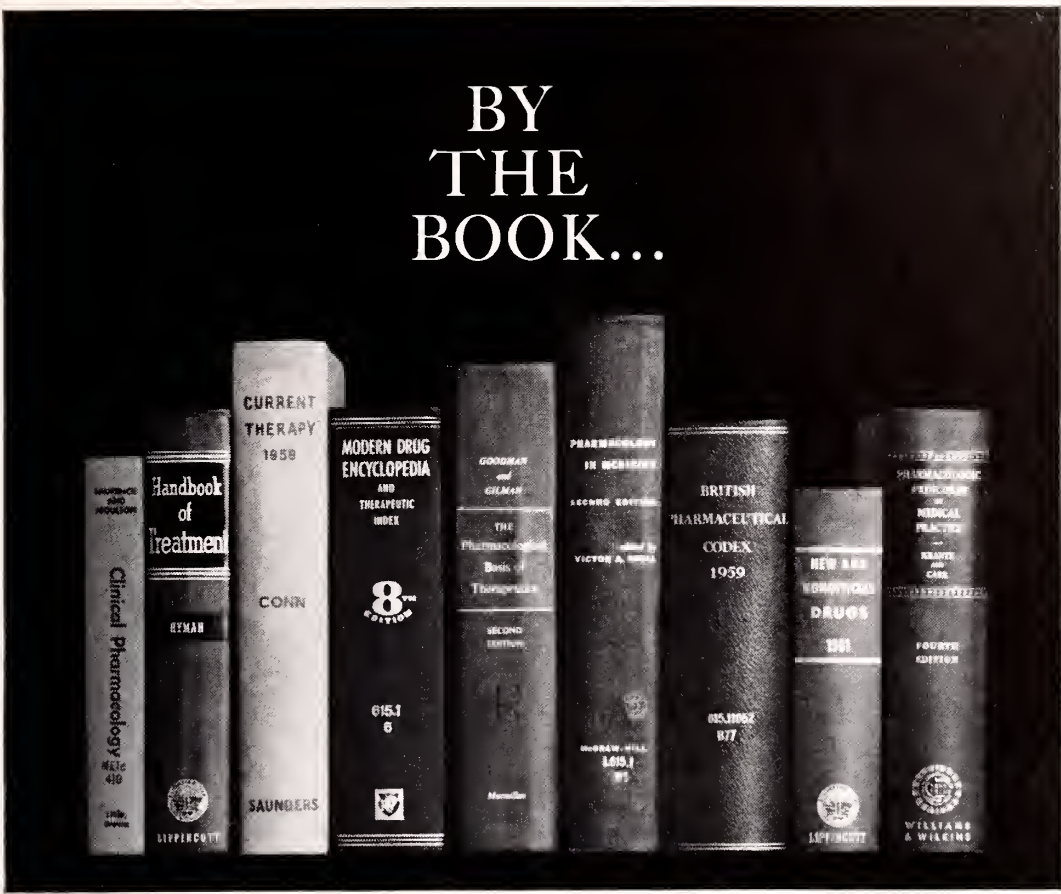
Dr. Curreri To Speak March 22

Anthony R. Curreri, M.D., professor of surgery at the University of Wisconsin, will give the 1963 annual Samuel D. Gross Lecture sponsored by the Phi Delta Epsilon medical fraternity of the University of Louisville School of Medicine, according to an announcement by Judah Skolnick, historian of the fraternity.

The lecture will be presented at noon March 22 in the Rankin Amphitheatre, Louisville General Hospital. Doctor Curreri's topic will be: "Chemotherapy in the Treatment of Far Advanced Anaplastic Disease." All members of the Kentucky State Medical Association and allied fields are invited.

Dr. Martin Speaks at Franklin

Homer B. Martin, M.D., Louisville general practitioner, addressed the Simpson County Chamber of Commerce January 29. The program was arranged by L. Focian Beasley, M.D., Franklin.



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Pro-Banthīne *with* Phenobarbital Tablets, containing 15 mg. of Pro-Banthīne and 15 mg. of phenobarbital.
Probital™ Tablets, containing 7.5 mg. of Pro-Banthīne and 15 mg. of phenobarbital.

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Digest of the Minutes of the KSMA Board of Trustees Meeting December 13, 1962

The President reported that the Council on Scientific Assembly and the Scientific Program Committee had met for the purpose of getting plans for the 1963 Annual Meeting underway and that the Specialty Group Presidents were scheduled to meet later in December on the 1963 Annual Session to be held in Lexington.

He reported that an excellent program had been arranged for the March 7 Interim Meeting in Covington.

The senior delegate from the KSMA to the AMA made his report on the Interim Meeting of the AMA House of Delegates to the Board of Trustees and stressed the highlights of the meeting.

Following this report, the President stated that due to the retirement of Hugh Hussey, M.D., Washington, D.C., as a member of the Board of Trustees of the AMA, a vacancy had been created on the AMA Board of Trustees. He stated that our senior delegate, Doctor Long, had been encouraged to make the race for this position. Following a brief discussion, the Board of Trustees unanimously agreed to support Doctor Long when the election is held at the Annual Meeting of the AMA in June 1963 at Atlantic City.

The recommendation of the Council on Postgraduate Medical Education and Hospitals relative to the reorganized office of continuing medical education was heard. The recommendation was that a new secretary-stenographer be employed with the continuing medical education office paying one-third of her salary and that she was to keep the master schedule of all postgraduate meetings held in Kentucky and that the material for the postgraduate page in The Journal of KSMA would be kept by her, that she was to work under the supervision of Robert G. Cox, who would serve as secretary to the Committee. The recommendation passed.

The President stated that the Kentucky Urological Society had petitioned the Board to become one of the cooperating specialty group societies participating in our Annual Meeting. The recommendation was unanimously accepted.

The Board accepted the recommendation of the Council on Scientific Assembly relating to awards. This recommendation was that the award given for the best scientific exhibit and the two awards for programs carried out by the faculty members of the two universities for outstanding service would be given, not necessarily every year, at an appropriate time during the scientific assembly instead of at the President's Luncheon. The recommendation passed.

Due to reapportionment of Kentucky Congressional Districts and since there are only seven, it was necessary to reorganize the KSMA Legislative District Key Man System. The nominations of the Council on Legislative Activities for these seven positions were presented and the Key Men were appointed.

The Trustees accepted the recommendation of the Council on Scientific Assembly that KEMPAC (Kentucky Educational Medical Political Action Committee) as the political arm of the medical profession should be the agency to interview the candidates for governor.

The recommendation of the Executive Committee to the Board of Trustees relative to holding meetings in all of the trustee districts on political action was considered and accepted. The House of Delegates' mandate to the Council on Legislative Activities to develop and present a program of general education for the public on operation of cults in Kentucky was considered and a progress report of the Council was made.

The mandate of the House of Delegates for the Board of Trustees to study the matter of reapportionment of the trustee district system in Kentucky was referred to the KSMA Bylaws Committee.

After reports by the various trustee district grievance committees, the President called attention to the efforts of the Association to get its members to affiliate with the Kentucky Chamber of Commerce. The recommendations of the Membership and Placement Committee were presented by its Chairman Claude E. Cummins, Jr., M.D., Maysville, in a full report explaining the inadequancies of our present system of keeping records of physicians in Kentucky and he stated that after careful consideration and consultation with the secretary of the State Board of Health that his committee was recommending an annual registration of all Kentucky physicians and pointed out that this could be done without charging a fee or passing a law.

After discussion, it was voted that there be a recommendation to the House of Delegates from the Board of Trustees that this plan be approved.

It was then pointed out that Wyatt Norvell, M.D., trustee from the Seventh District, upon being elected as a delegate from KSMA to the AMA had resigned as trustee pending the appointment of a replacement. President Cox stated that as provided by the Bylaws the Seventh District had been polled by him and that Donald Chatham, M.D., Shelbyville, had received a substantial majority of the nominations. Following discussion, Doctor Chatham was elected to serve as trustee from the Seventh District until the next regular meeting of the House of Delegates.

There was a discussion of the meeting called by the Governor at Harlan, Ky. on January 10 to discuss what should be done about the four UMWA Hospitals that the Union is planning to close June 1. Inasmuch as the Association had been asked to send representatives, it was felt that these representatives should be given some instruction. Following discussion, the Board authorized its representatives to make sure certain basic principles in the operation of hospitals and their relationship with the community and the union could be stressed.

It was decided that the date of the next meeting of the Board would be Wednesday, March 6, at 4 p.m., at the Town and Country Restaurant at Covington just prior to the 1963 Interim Meeting on March 7 at the same location.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1963 Annual Meeting — Kentucky State Medical Association

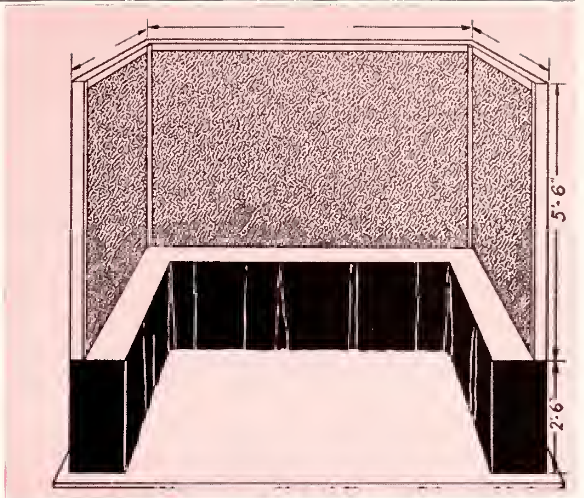
Phoenix Hotel — Lexington, Kentucky — September 23, 24, 25, 26

Fill Out and Mail to:

J. ALEX HALLER, M.D., Chairman
Committee on Scientific Exhibits
Department of Surgery
University of Louisville
511 S. Floyd Street
Louisville 2, Kentucky

Applications for space should be received before July 1, 1963

Dimensions and structure of KSMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: ....
2. Name (s) of Exhibitor (s): ....

   ....

   Institution (if desired): ....

   Mailing Address ....
3. Do you have a built-in exhibit? ....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)

   Charts and Posters.... Photographs.... Drawings.... X-rays....

   Specimens.... Moulages.... Other Material ....
   (Describe)
6. Booth Requirements:

   Amount of wall space needed? ....

   Back wall ....Side walls ....

   Square feet needed? ....

   Shelf desired? (yes or no) ....
7. Has This Exhibit Been Exhibited Before? (yes or no) ....

Date ....
Signature of Applicant

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KSMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

MEDICAL SCHOOL NEWS

U. of L. Anatomy Laboratory Named for Doctor Cole

The anatomy laboratory at the University of Louisville School of Medicine was named the "Arch E. Cole Memorial Laboratory" at a special ceremony February 12 at the General Hospital amphitheatre. It memorializes the late Doctor Cole who was killed in an automobile accident in July 1962.

Jerry Buchanan, Charleston S. C., president of the U. of L. Chapter of the Student American Medical Association, presented the plaque which will be placed in the laboratory. A new laboratory, to be located in the proposed new Medical School building, will also be named in Doctor Cole's honor.

Sydney E. Johnson, M.D., now of St. Petersburg, Fla., professor emeritus of radiology at the U. of L., gave the memorial address. The ceremony was attended by Doctor Cole's son and two daughters. Doctor Cole, who was 67 at the time of his death, had been with the U. of L. since 1929 and was five times voted "preclinical professor of the year" by students.

Franklin Gordon Hoffman, M.D., has been named assistant professor of medicine at the U. of L. David H. Neustadt, M.D., has been advanced from instructor to assistant professor of medicine. Charles McGaff, M.D., has resigned as assistant professor of medicine to enter private practice at Toledo, Ohio, and Arthur C. White, M.D., has resigned as assistant professor of medicine to go with the Medical College of Georgia at Augusta.

William Leslie Miller, resident in pathology, has received a $10,000 one-year grant for research and teaching in cancer diagnosis from the U. S. Public Health Service.

Dr. Githens Resigns at U. of K.

John H. Githens, M.D., has resigned as head of the Pediatrics Department of the University of Kentucky College of Medicine. He plans to return to Colorado.

M. Lois Murphy, M.D., associate attending pediatrician, Memorial Hospital, Sloan Kettering Cancer Center, will be second lecturer in the series of cancer-teaching lectures March 21 at the University of Kentucky Medical Center, Lexington, speaking on "Chemotherapy of Tumors in Children."

Anesthesiology Course Slated

The Cleveland Clinic Educational Foundation will present a postgraduate course, "A Decade of Progress in Anesthesiology," April 17-18. Additional information may be obtained from Walter J. Zeiter, M.D., Cleveland Clinic Educational Foundation, 2020 East 93rd St., Cleveland 6, Ohio.

Work of Medical Assistants Praised by Dr. Bosworth

N. Lewis Bosworth, M.D., Lexington, chairman of the KSMA Council on Communications and Public Service, stated that physicians appreciate the work of their medical assistants. He added that they also appreciate their official organization.

This action was taken by the Council at its meeting in January when it commended the medical assistants of Kentucky for their excellent work and encouraged their attendance at the forthcoming first annual meeting of the Kentucky Association of Medical Assistants at Louisville in May.

The Council on Communications and Public Service, which was partially responsible for the organization of KAMA, urged every physician who has in his employ or under his supervision medical assistants who are eligible for membership in KAMA to encourage all these assistants to join that organization and actively participate in its programs.

Public Health Group To Meet

Governor Bert T. Combs of Kentucky, State Health Commissioner Russell E. Teague, M.D., and Dean William R. Willard, M.D., of the University of Kentucky College of Medicine will address the Tuesday morning opening session of the Kentucky Public Health Association's 15th annual meeting at the Kentucky Hotel, Louisville, April 9-11.

There will be combined section meetings on Tuesday and Wednesday afternoons and section meetings Wednesday morning. Helen Fraser, M.D., Division of Maternal and Child Health, Kentucky State Health Department, and Ward Holm, Indiana Dairy Products Association, will discuss "Health Behind the Iron Curtain" at the second general session Wednesday evening. Miss Sara C. Stice, Frankfort, is president of the KPHA and Nick Johnson, Frankfort, is president-elect.

Industrial Physicians To Meet April 4

The Kentucky Industrial Medical Association will hold its annual meeting at the Holiday Inn Northeast, Louisville, April 4, beginning at 2 p.m.

Thomas M. Marshall, M.D., will speak on "Neurological Considerations of the Upper Extremity"; Thomas E. Booth, M.D., "Advances in Modern Otology"; Homer Martin, M.D., "Satisfactory Treatment of the Nervous Patient", and Daniel G. Costigan, M.D., "The Knee". All are from Louisville. A social hour and dinner will follow the program. A business meeting and election of officers will close the meeting.

Grant Co. Hospital To Enlarge

Grant County Hospital, Williamstown, Ky., plans a one-story 25-bed addition which will cost $550,000. The hospital has received a $275,000 grant under the Hill-Burton Act from the Public Health Service to help finance the cost.

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"It is not unusual for patients on a low-calorie diet to feel low, irritable, and tired during the first two or three weeks."* In contrast, the dieting patient on 'Dexamyl' usually gains a brighter outlook, a feeling of energy and general well-being, and, most important, confidence that she really can lose weight after all! In addition to its mood effect, one 'Dexamyl' Spansule® sustained release capsule taken in the morning effectively curbs appetite all day—both at and between meals.

**Matlin, E.: The Obvious in Obesity, Clin. Med. 8:1071 (June) 1961.*

FORMULA: Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine® (brand of dextro amphetamine sulfate) and 1½ gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of 'Dexedrine' (brand of dextro amphetamine sulfate) and 1 gr. of amobarbital [Warning, may be habit forming]. The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12 hours.

INDICATIONS: (1) For control of appetite in overweight; (2) for mood elevation in depressive states.

USUAL DOSAGE: One 'Dexamyl' *Spansule* capsule taken in the morning for 10- to 12-hour therapeutic effect.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Use with caution in patients hypersensitive to sympathomimetic compounds or barbiturates and in coronary or cardiovascular disease or severe hypertension.

SUPPLIED: Bottles of 50 capsules.

Smith Kline & French Laboratories *Prescribing information October 1962*

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

In Kentucky

MARCH

21 — Monthly University Surgical Day, "Endocrine Surgery," University of Kentucky Medical Center, Lexington, Ky.

27-28 — Symposium on Cardiovascular Diseases, Brown Hotel, Louisville, Ky.

APRIL

1-4 — Kentucky Hospital Association, Annual Convention, Kentucky Hotel, Louisville, Ky.

4 — Annual Meeting, Kentucky Industrial Medical Association, Holiday Inn Northeast, Louisville, Ky.

9-11 — Kentucky Public Health Association, Annual Meeting, Kentucky Hotel, Louisville, Ky.

18 — Monthly University Surgical Day, "Cancer Surgery," University of Kentucky Medical Center, Lexington, Ky.

24 — Kentucky Psychiatric Association, Holiday Inn, Lexington, Ky.

25-26 — "Thoracic Diseases," University of Kentucky Medical School, Lexington, Ky.

MAY

8-10 — Kentucky Academy of General Practice, Annual Meeting, Kentucky Hotel, Louisville, Ky.

9-11 — "Cardiology," University of Kentucky Medical Center, Lexington, Ky.

10-12 — Kentucky Obstetrical and Gynecological Society, Annual Meeting, Campbell House, Lexington, Ky.

15-16 — Kentucky Pediatric Society and Kentucky Chapter, American Academy of Pediatrics, Lexington, Ky.

16 — Monthly University Surgical Day, "Surgical Physiology," University of Kentucky Medical Center, Lexington, Ky.

17-18 — Kentucky Surgical Society, University of Kentucky Medical Center, Lexington, Ky.

Surrounding States

MARCH

11-14 — American College of Surgeons, Penn Sheraton Hotel, Pittsburgh, Pa.

12-14 — "Gynecologic Problems in Private Practice," Medical College of Georgia, Augusta, Ga.

13-14 — Obstetrics and Gynecology, Indiana University Medical Center, Indianapolis, Ind.

18-19 — Southeastern Surgical Congress, Miami Beach, Fla.

20 — "One Day Symposium on Allergy for the General Practitioner and Internist," Ohio State University College of Medicine, Columbus, Ohio.

25-April 6 — Anatomical and Clinical Otolaryngology, Indiana University Medical Center, Indianapolis, Ind.

28-30 — Fourth Oklahoma Colloquy on Advances in Medicine: Pulmonary Insufficiency, Oklahoma City, Okla.

29-April 4 — American Academy of General Practice, Chicago, Ill.

APRIL

1-5 — American College of Physicians, City Auditorium, Denver, Colo.

1-5 — 36th Annual Spring Congress in Ophthalmology and Otolaryngology, Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va.

4 — Seminar on "Premature Care," Good Samaritan Hospital, Cincinnati, Ohio.

10-11 — Clinical Heart Disease, Indiana University Medical Center, Indianapolis, Ind.

MAY

1-2 — Ninth Annual Seminar, Cancer-Emphasis on Chemotherapy, Huron Road Hospital, Cleveland, Ohio.

JUNE

16-20 — Annual Meeting, American Medical Association, Auditorium & Convention Hall, Atlantic City, New Jersey

24-27 — American Orthopaedic Association, The Homestead, Hot Springs, Va.

24-28 — Internal Medicine: Current Physiological Concepts in Diagnosis and Treatment, American College of Physicians Course, Cincinnati General Hospital and University of Cincinnati College of Medicine, Cincinnati, Ohio.

The University of Kentucky Monthly Surgical Day Program on "Endocrine Surgery," March 21, 1963, will begin at 8 a.m. with the observation of cases in the operating room. The remainder of the morning will include rounds on the surgical wards at the University Hospital, Lexington, Ky. The afternoon program from 1 to 3 p.m. will consist of problems in gastrointestinal surgery.

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Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.
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Phenylephrine Hydrochloride	10 mg.
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Sodium Citrate	85 mg.

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Literature on request

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Bailey Memorial Fund Assists Two Medical Students

Two Harlan County medical students—Norman Edwards, in his third year at the University of Louisville, and James M. McClurkan, in his second year at Tulane—are being assisted with loans from the Clark W. Bailey Memorial Fund.

The Fund was established in 1957 in memory of the late Doctor Bailey, Harlan, a former president of the Kentucky State Medical Association. It was started by the Harlan County Medical Society and is a revolving fund which requires repayment of loans beginning five years after graduation from medical school. Gifts to the fund have been made by many colleagues, friends and former patients of Doctor Bailey.

Present board of directors is as follows: Edward Cawood, C. L. Smith, S. L. Rowland, M.D., Gilbert Hamilton. M.D., John H. Willard, M.D. and Clark W. Bailey, Jr., treasurer.

Ky. Surgeons on College Program

Rudolf J. Noer, M.D., professor and chairman of the Department of Surgery, and Pat R. Imes, M.D., professor of surgery at the University of Louisville School of Medicine, participated in the program at the sectional meeting of the American College of Surgeons at Charlotte, N. C., February 11-13. Doctor Noer was moderator of, and Doctor Imes a member of a panel on colo-rectal surgery. Doctor Noer also presented a paper on "Application of Cancer Chemotherapy in the Community Hospital."

Dr. Burke Now at Outwood

Thomas F. Burke, M.D., has been named clinical director at Outwood Hospital, Dawson Springs, Ky. Doctor Burke, previously a staff physician at Western State Hospital, Hopkinsville, has recently spent several months as a staff psychiatrist at Northeast Florida State Hospital.

Marvin Logsdon, on leave from Western State Hospital as acting administrator at Outwood, was named permanent administrator January 1.

H. S. Gilmore, M.D., Honored

In connection with the opening of the new Bath County Medical Center January 19-20 at Owingsville, tribute was paid to H. S. Gilmore, M.D., 80, Owingsville, who has practiced medicine for well over a half-century.

Doctor Gilmore was graduated from the Kentucky University Medical Department at Louisville in 1905 and is a part-time specialist in pediatrics. He was instrumental in establishing the Medical Center.

Dr. Douglas Heads Radiologists

James B. Douglas, M.D., was elected president of the Kentucky Society of Radiologists at the January meeting of the Society. Ji-toong Ling, M.D., was named president-elect, and Lawrence A. Davis, M.D., was re-elected secretary-treasurer.

KSMA Council, Committee Reports

Federal Medical Services Committee

L. F. Beasley, M.D., Chairman

Louisville **February 7, 1963**

The Federal Medical Services Committee met with representatives of the Veterans Administration and Kentucky Physicians Mutual (Kentucky's Blue Shield Plan) on February 7 at the KSMA Headquarters Office.

The Chairman stated that this committee is responsible for two contracts with the government. One is the Hometown Medical Care Contract with the VA and the second is the contract with the Washington Office of Dependents Medical Care for dependents of members of the Armed Forces.

Representatives of the VA summarized the program under the Hometown Medical Care Contract and stated that there were no real problems at the present time. The Medicare Contract, which is between KSMA and the Department of Defense, was summarized by a representative of Kentucky Physicians Mutual (which is the KSMA fiscal agent) and it was noted that there were no complaints or problems concerning this contract.

The committee recommended to the Board of Trustees through the Council on Medical Services that these contracts be renewed the coming year as they now exist, as there have been no complaints or problems with either contract.

Medicare Review Committee

Henry Collier, M.D., Chairman

Louisville **January 21, 1963**

The Medicare Review Committee met on January 31 at the Blue Cross-Blue Shield Headquarters Office, Louisville, with representatives of the Washington Office of the Dependents' Medical Care and representatives of Blue Cross-Blue Shield.

Representatives of ODMC outlined the purpose of the local review committee and discussed the contract between KSMA and the federal government which provides medical care for dependents of Armed Forces personnel.

Representatives of Kentucky Physicians Mutual (Kentucky's Blue Shield Plan) explained their role as fiscal administrators of the contract and reviewed the processing of physicians' medicare claims.

A number of example claims were presented to the committee for discussion and recommendation.

Council On Communications And Public Service

N. Lewis Bosworth, M.D., Chairman

Louisville **January 17, 1963**

The Council on Communications and Public Service held its first meeting of the year on January 17, at KSMA Headquarters. The members of the Council discussed an indoctrination program for new members and appointed a sub-committee to study this matter in detail and to report to the Council at a later meeting.

The various committees under the Council submitted their reports and recommendations for the remainder of the year. Resolutions that were passed by the House of Delegates and discussed at this meeting

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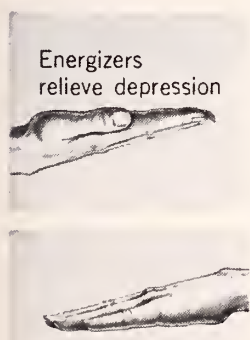

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included a resolution on "Endorsing AMA Action Relative to Social Security," "Resolution on Physical Education," and a "Resolution of Appreciation on the Woman's Auxiliary."

The Council approved exhibits for the 1963 meetings of the Kentucky School Board, Kentucky Education Association, Kentucky State Fair and the KSMA Annual Meeting. They also recommended that KSMA participate in this year's Health-O-Drama at the State Fair.

The Council approved the recommendation of the Highway Safety Committee concerning the investigation of fatal highway collisions but disapproved the method by which this would be implemented by way of U. S. government channels.

Highway Safety Committee

Arthur H. Keeney, M.D., Chairman

Louisville **January 3, 1963**

The Highway Safety Committee met in the KSMA Headquarters Building January 3, 1963, with representatives of the Departments of Safety and Health.

Medical Aspects of Driver Limitation were analyzed and the Committee scheduled a joint meeting with the state and national health agencies to implement medical recommendations within existing Kentucky Revised Statutes. These have long charged the Division of State Police to deny licenses to individuals who are physically unable to operate motor vehicles with reasonable safety. No modus operandi, however, has been established to implement these charges.

The Chairman reported that five organizations (including two Louisville taxicab companies) have received the KSMA Automotive Safety Award for 100% seat belt installation.

The Committee reviewed the completed first phase of the Kentucky-Cornell Automotive Crash Injury Research Program. The second phase sampling area was begun in 13 counties on February 1 and will continue for six months. Quality of physician and trooper reports has been excellent, but volume has been slightly below anticipated levels. Cornell representatives complimented Kentucky physicians on their individual work in these reports. The Committee endorsed a program of research on single occupant fatal highway accidents and recommended the program to the Board of Trustees through the Council on Communications and Public Service.

Advisory Committee to the Editor

George F. Brockman, M.D., Chairman

Louisville **January 10, 1963**

The meeting of the Advisory Committee to the Editor was held at the Headquarters Office Building, Louisville, January 10.

"Endocrine Diseases" will be the subject of the 1963 symposium issue of The Journal in October. Beverly Towery, M.D., Louisville, is symposium editor. Plans for an issue dealing with Emergency Federal Services, probably in September, were discussed.

The new front cover design with the revised sketch was accepted. The appointment of Eugene H. Conner, M.D., Louisville, to succeed Walter S. Coe, M.D., Louisville, as book review editor was announced. Doctor Coe is now associate editor of The Journal.

Plans for a 60th anniversary issue were discussed. It is tentatively scheduled for the November 1963 Journal.

A suggested list of replacements for those whose terms expire June 30, 1963, as members of the Board of Consultants on Scientific Articles was approved.

Student AMA

U. of K. Chapter Reports on Group Activities

The officers of the Student AMA chapter at the University of Kentucky attended the 13th Annual Interim Meeting of the Kentucky State Medical Association, which was held in Covington, Ky., March 7.

Other activities in which we are involved are a dance which was sponsored for the medical students at the Spring Valley Country Club on March 9; and there will be selection of the outstanding preclinical teacher who will receive the "Golden Apple" award in May.

Our meetings this past year have been very interesting and informative, two of the outstanding speakers we have heard are: Beverly T. Mead, M.D., assistant professor, Department of Psychiatry, who spoke in October, on "Who Wants To Be A Doctor?"; and Rudolph J. Muelling, Jr., M.D., professor of pathology, and head, division of Legal Medicine and Toxicology, Department of Pathology, who spoke in December, on "Blood Alcohol Levels in Intoxication."

Ballard Wright, President
U of K Chapter SAMA

U. of L. SAMA Compliments Student-Physician Plan

Last month, SAMA initiated its annual student-physician four-year friendship program. This program is made possible only through the cooperation and efforts of the Jefferson County Medical Society. This year, as in the years before, we are grateful for the concern that has been demonstrated by the participating physicians.

The program consists of matching the entering freshman medical students with physicians of the Jefferson County Medical Society. The physician acts as a friend and non-academic advisor for the student through his four years of medical school. During these years, the physician acquaints the student with his clinical practice, his group and society meetings and his home life. Thus, the physician serves as a means of escape from the preclinical world of cold facts and basic principles and allows the student a glimpse into the clinical world of application and rewards.

The students are grateful for this opportunity to work with the physicians of Jefferson County. We sincerely appreciate the interest that they have shown in us by participating in this program. SAMA is happy to have a part in sponsoring the program again this year.

Jerry B. Buchanan, President
U. of L. Chapter SAMA

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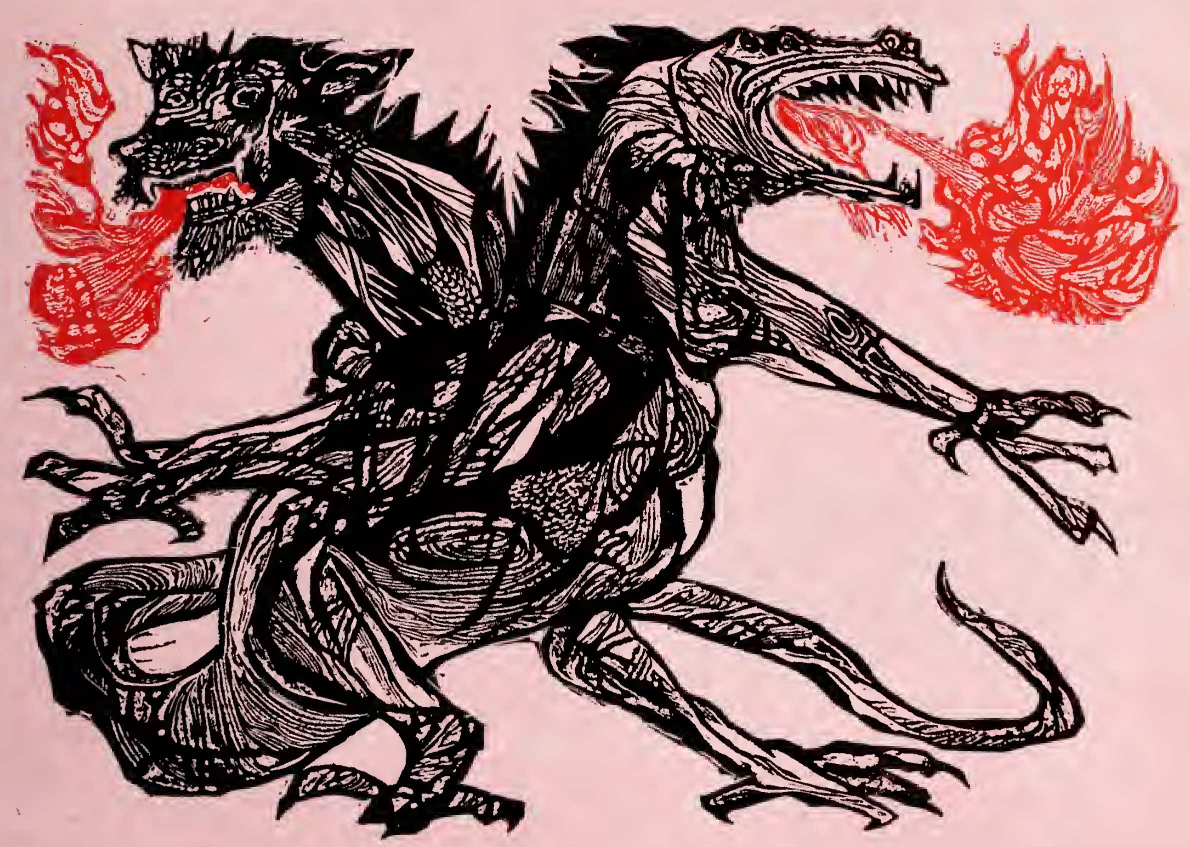

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County Society Reports

Jefferson

George A. Sehlinger, M.D., urologist, was named president-elect of the Jefferson County Medical Society January 21, as Louis M. Foltz, M.D., psychiatrist, took office as president. Retiring president is Everett H. Baker, M.D., anesthesiologist.

Charles G. Bryant, M.D., general practitioner, was named first vice president; Thomas M. Marshall, M.D., neurosurgeon, second vice president; Robert W. Lykins, M.D., anesthesiologist, secretary, and William P. VonderHaar, M.D., general practitioner, treasurer. All the officers are from Louisville.

The Society presented its sixth annual lay award jointly to two public relations specialists for their work in the 1962 Sabin oral polio immunization drive in Jefferson County. They are: Ken D. Thompson and Calvin D. Anderson, who were cited in the award for "demonstrating the unique ability to interpret a great public health opportunity and translate it into public response."

Bourbon

William E. Davis, M.D., North Middletown, was elected president of the Bourbon County Medical Society January 4, succeeding Marvin B. Dillon, M.D., Paris. Doctor Davis is Bourbon County health officer. Other new officers are: Vice president, James E. Johnson, Jr., M.D., Millersburg, and secretary, James L. Farrell, M.D., Paris.

Henderson

Clarence J. McGruder, Jr., M.D., was named president of the Henderson County Medical Society at its annual meeting January 30. Doctor McGruder succeeds Donald A. Cantley, Jr., M.D. New vice president is J. Leland Tanner, M.D., and John L. Jenkins, M.D., was reelected secretary-treasurer.

Kenneth M. Eblen, M.D., was named delegate to the KSMA and Robert L. Sumner, M.D., alternate.

New officers of the Simpson County Medical Society, elected in October 1962, are as follows: L. F. Beasley, M.D., president; J. Carter Moore, M.D., vice president; A. V. Wilwayco, M.D., secretary. All are from Franklin.

Doctor Lynn's Clinic Burns

The 10-room clinic of Ralph D. Lynn, M.D., Elkton, was destroyed by fire February 16. All 16 outpatients in the clinic at the time were safely evacuated. Doctor Lynn, who set up an office in a vacant building near the clinic, said he was able to save only his office records and some office equipment. Doctor Lynn is a former member of the KSMA Board of Trustees and is a member of the Board of Trustees of Kentucky Physicians Mutual.

Psychiatrists To Meet April 24

The Kentucky Psychiatric Association will meet April 24 at the Holiday Inn, Lexington. Guest speaker will be Stella Chess, M.D., New York City, who will speak on "Psychotherapeutic Activity with the Mentally Retarded."

Symposium on Auscultation

A symposium on "The Theory and Practice of Auscultation" will be sponsored by the Hahnemann Medical College and Hospital at the Sheraton Hotel, Philadelphia, April 15-17. Director is Bernard L. Segal, M.D.

Subjects to be covered include: "The Physics and Registration of Heart Sounds and Murmurs," "Heart Sounds and Murmurs in Health and Disease," "The Auscultatory Recognition of Congenital Heart Disease," "Auscultation as an Aid to Clinical Diagnosis in Miscellaneous Cardiovascular Problems," "The Diagnosis and Treatment of Congenital Heart Disease," "The Use and Misuse of the Stethoscope," "The Auscultatory and Phonocardiographic Diagnosis of Rheumatic Heart Disease" and "Recent Laboratory Developments."

Dr. Garrett Named Man of Year

Morris M. Garrett, M.D., Fort Thomas, Ky., radiologist, was named Man of the Year for 1962 by past commanders of Newport Chapter 37, Disabled American Veterans. Doctor Garrett, a 1949 graduate of the University of Louisville School of Medicine, was cited for his work in the polio vaccination program in Northern Kentucky and with civil defense in the area. He will receive a national DAV scroll at a dinner in June. He is immediate past president of the Campbell-Kenton County Medical Society.

In Memoriam

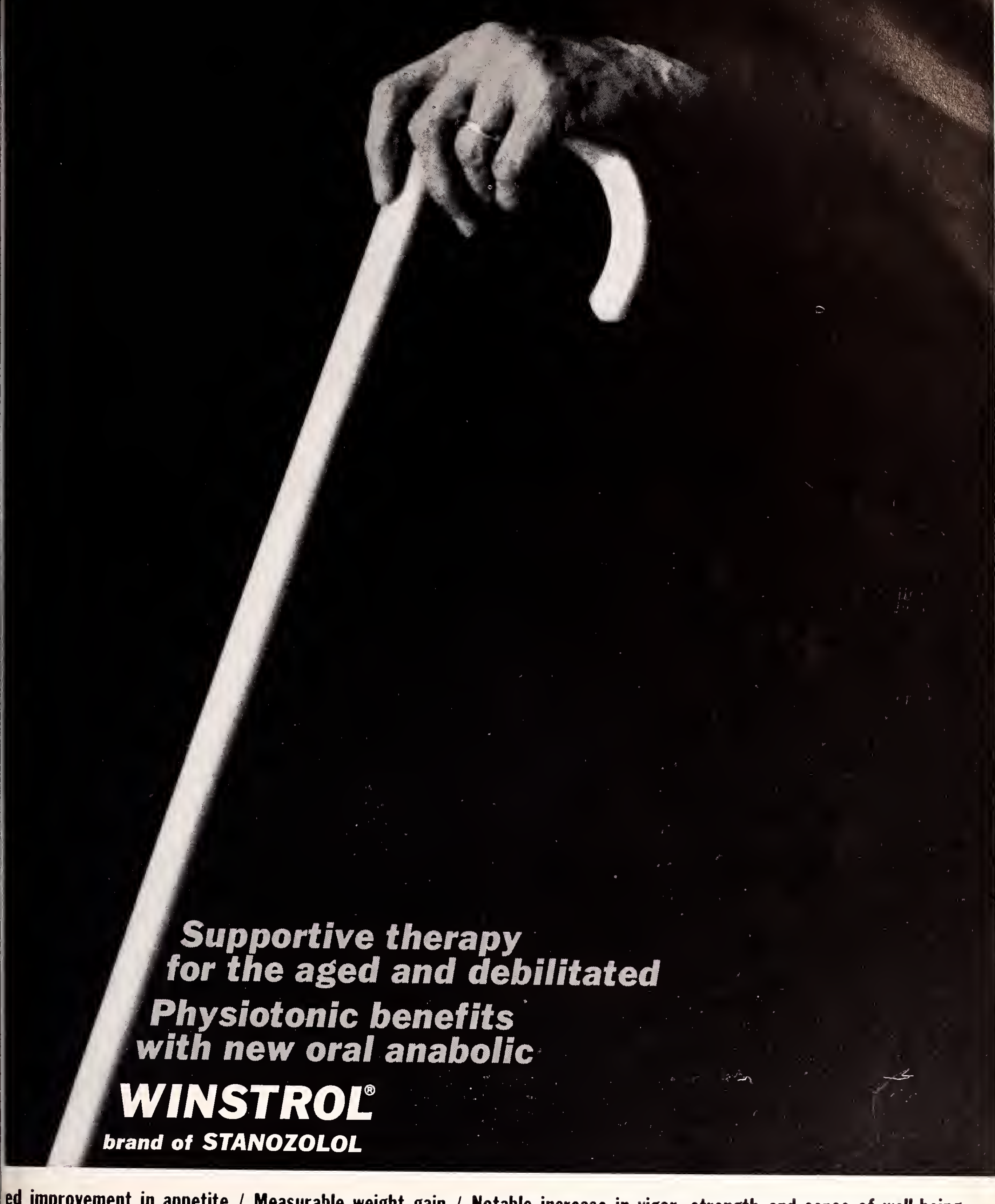
WINSTON NICHOLS BLOCH, M.D.
Louisville
1909-1963

Winston Nichols Bloch, M.D., 53, Louisville, Ky., surgeon, died of a heart attack January 26 at his office. Doctor Bloch was graduated from the University of Louisville School of Medicine in 1935. He interned at General Hospital, Louisville, and studied surgery at New York City Polyclinic Hospital. He entered practice at Louisville in 1940 with his father, the late Leo Bloch, M.D.

Doctor Bloch served in the U. S. Army Medical Corps during World War II and took part in the invasion of Okinawa. He entered service as a captain and was discharged as a lieutenant colonel.

MICHAEL BRANDENBURG
Pineville
1875-1963

Michael Brandenburg, M.D., 87, Pineville, Ky., died at his home January 21 after several months of illness. Doctor Brandenburg was graduated from the University of Texas Medical School in 1898 and practiced at Cincinnati, Ohio, and Asher, Okla., before moving to Pineville in 1903.



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PUBLIC HEALTH PAGE

Public Health in Relation to the Private Practice of Medicine

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

THE House of Delegates of the American Medical Association at its last meeting accepted four recommendations presented to it by the Board of Trustees in a supplementary report on Public Health in Relation to the Private Practice of Medicine:[1]

1. "That the state and county medical societies be encouraged to evaluate periodically their public health department's activities in terms of local health needs, programs, and resources."

2. "That state and county medical societies ascertain and acknowledge that public health departments should include at least the following basic services: (a) Vital statistics. (b) Public health education. (c) Environmental sanitation. (d) Public health laboratories, if private facilities are unavailable. (e) Prevention and control of communicable diseases. (f) Hygiene of maternity, infancy, and childhood, if private facilities are unavailable."

3. "That the policy statement on public health services of the American Medical Association be as follows: 'Public Health is the art and science of maintaining, protecting, and improving the health of the people through organized community efforts. It includes those arrangements whereby the community provides medical services for special groups of persons and is concerned with prevention or control of disease, with persons requiring hospitalization to protect the community, and with the medically indigent.'

4. "That state and county medical societies should collaborate with departments of public health in the interest of community health, always keeping in mind the need for a proper balance between local public health programs and the private practice of medicine.

Within the past few years there has been a change in the concept of public health. The emphasis has shifted from what previously was solely considered to be "prevention of disease," particularly those communicable diseases for which medical science has developed vaccines, or effective antigens that will develop protective antibodies in the human body. The new emphasis has shifted to include attention to community facilities for providing adequate medical care through community effort to people who need medical services and who otherwise would be denied those services.

There are a few milestones that may be responsible for the change of emphasis or the new concept.

(1) For years, physicians, both in private practice and in public health, have tried to define the specific roles of the private practitioner of medicine and the public health physician. It seems that we are beginning to realize that there should be no difference between the philosophies of the two specialties.

(2) There seems to be developing a recognition that neither group alone can provide what has been referred to as "comprehensive" medical care for all the people who need it, and that there is a need to know what are the problems or medical needs and what we are doing to control the problem or meet the needs. Growing out of this approach, both medicine and government are beginning to face the problems realistically. To substantiate this observation, we have only to look at recent Kentucky legislation sponsored by the Kentucky State Medical Association and observe what is being done for the indigent and medically indigent segments of our population in the new care program.

(3) No one wants to deny medical care to anyone who needs it. There frequently are differences of opinions as to how that care is to be provided. A number of methods or programs may have to be developed and tried before a generally accepted procedure is found. Of necessity, programs will differ in time and place according to local health needs.

Having realized that health problems do exist in our communities, we are willing to try new methods or programs to control these health problems.

There appears to be a great need for medical societies and boards of health, private practitioners and public health physicians, to analyze and evaluate programs to meet objectives for community health needs; to give guidance and direction at the right time and place so that together we do not create a

[1] *American Medical Association—The J.A.M.A., Vol. 182, No. 10, December 8, 1962.*

This article was prepared by Edward M. Thompson, M.D., director of local health, office of the Commissioner, Kentucky State Health Department, Frankfort, Ky.

Frankenstein monster that will destroy our economy or reduce our freedoms.

One of our revered physicians and statesmen of the past, Haven Emerson, M.D., once presented a paper "Whither the Pegasus of Public Health?" In this paper he referred to public health as the offspring resulting from the marriage of government and medicine. He pointed out that government has some responsibility for providing health facilities for people who could not provide them for themselves; e.g., community sanitation services such as public sewage and water systems and measures for controlling such diseases as tuberculosis and venereal disease. Medical science is constantly making new discoveries which private physicians cannot make generally available through community-wide application. Doctor Emerson pointed out that public health was the channel through which this knowledge, with discretion, might and ought to be applied.

"Strong Maladies . . ."

(Continued from page 252)

It is important that the entire medical profession understand the basic issues in this struggle so that they can recognize the difference between compromise and surrender. Again, the great weapon at our command is the truth.

There can be no compromise on our basic principles, and there can be no alternatives.

We can justify our present position because it is sound. We believe in helping those who need help, and we believe that the solvent and self-reliant should help themselves.

Can anyone argue with that?

Our position is sound because we have supported and still support the Kerr-Mills Law which is designed to help those who need help without dissipating the tax resources of the nation's workers and their employers by providing health care to the millions of the aged who are not in need. Our position is sound because we believe that the Kerr-Mills Law, properly implemented by the states to help all the aged who need help, and voluntary health insurance and the prepayment plans, protecting those who are able to take care of themselves, will solve whatever problems exist among the aged in financing medical care.

The people will respond to the truth, and it is imperative that we as individuals and as an organization see that they get the truth.

Statistics provided by the Kentucky Heart Association and compiled from records of the Kentucky State Health Department show that in 1960 (the last year for which official statistics are available) 53.5% of all deaths were the result of heart and blood vessel diseases. In 1960 the total number of deaths from all causes was 29,909 with 16,013 the result of heart and blood vessel diseases.

An artificial leg for above-knee amputees, with an hy-draulic knee mechanism designed to make walking more graceful and efficient, is being issued to eligible veterans by the Veterans Administration.

News Notes

Daniel Leigh Weiss, M.D., has been named professor of pathology at the University of Kentucky Medical Center, Lexington. Doctor Weiss was graduated from Columbia University College of Physicians and Surgeons in 1946 and interned at the Hospital for Joint Diseases in New York City. He did his residency training at Mount Sinai Hospital and Beth Israel Hospital in New York. Doctor Weiss, while in the U. S. Army Medical Corps, as a first lieutenant and later captain 1947-49, was with Walter Reed Army Medical Center at Washington and Sixth Army Medical Laboratories at San Francisco. He was instructor in virology at the Army Medical School and chief of the virus and rickettsial disease section at the Sixth Army Laboratories. Before going to Lexington he was director of the Institute of Pathology and Laboratory Medicine at the District of Columbia General Hospital and served as clinical professor of pathology at George Washington University, Georgetown University and Howard University.

Robert G. Aug, M.D., psychiatrist, has joined the faculty of the University of Kentucky Medical Center, Lexington. Doctor Aug is a 1955 graduate of the University of Cincinnati School of Medicine and interned at Cincinnati General Hospital. For two years he was a resident in psychiatry at that hospital and for two additional years, a Fellow in child psychiatry. Doctor Aug served for two years in the U. S. Army Medical Corps as instructor in psychiatry at the Medical Field Service School at Brooke Army Medical Center, Fort Sam Houston, Texas. He was engaged in part-time private practice of psychiatry at Cincinnati while serving as a resident and Fellow.

A G. Schwyzer, M.D., orthopedist, has joined the Trover Clinic, Madisonville, Ky. Doctor Schwyzer was graduated from Johns Hopkins in 1939. He interned at St. Joseph's Hospital, St. Paul, Minn., and took residency training at the University of Minnesota and MPS General Hospital; at the Lahey Clinic, Boston, in neurosurgery, and at the Cleveland Clinic in orthopedics. He served for two years as a major in the Medical Corps. Previously Doctor Schwyzer was with the Wheeling, W. Va., Clinic, and the Huntington, W. Va., Orthopedic Hospital.

Edward Bowling, M.D., formerly in practice at Lebanon, has associated with **W. H. Cave, M.D.,** at Henderson, Ky., for the practice of general surgery and proctology. Doctor Bowling has recently returned from study at the Mayo Clinic at Rochester, Minn., where he completed his training in proctology. He is a 1952 graduate of the University of Louisville School of Medicine.

Robert F. Long, M.D., Somerset, Ky., radiologist, has relinquished his practice at Mount Mary Hospital, Hazard, and will devote all of his time to practice in the Somerset General Hospital. He is succeeded at Hazard by Y. S. Leung, M.D., Paintsville.

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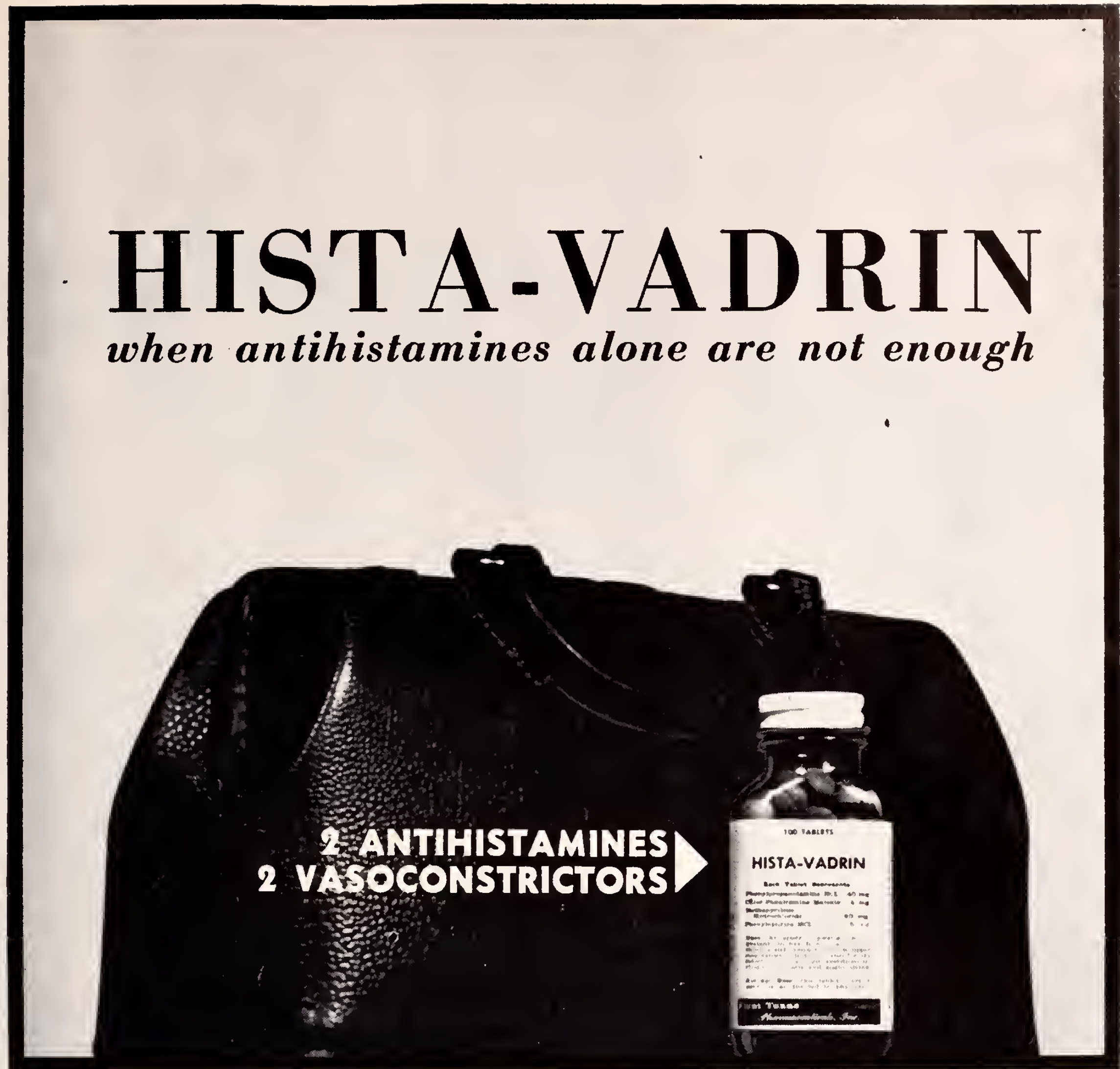

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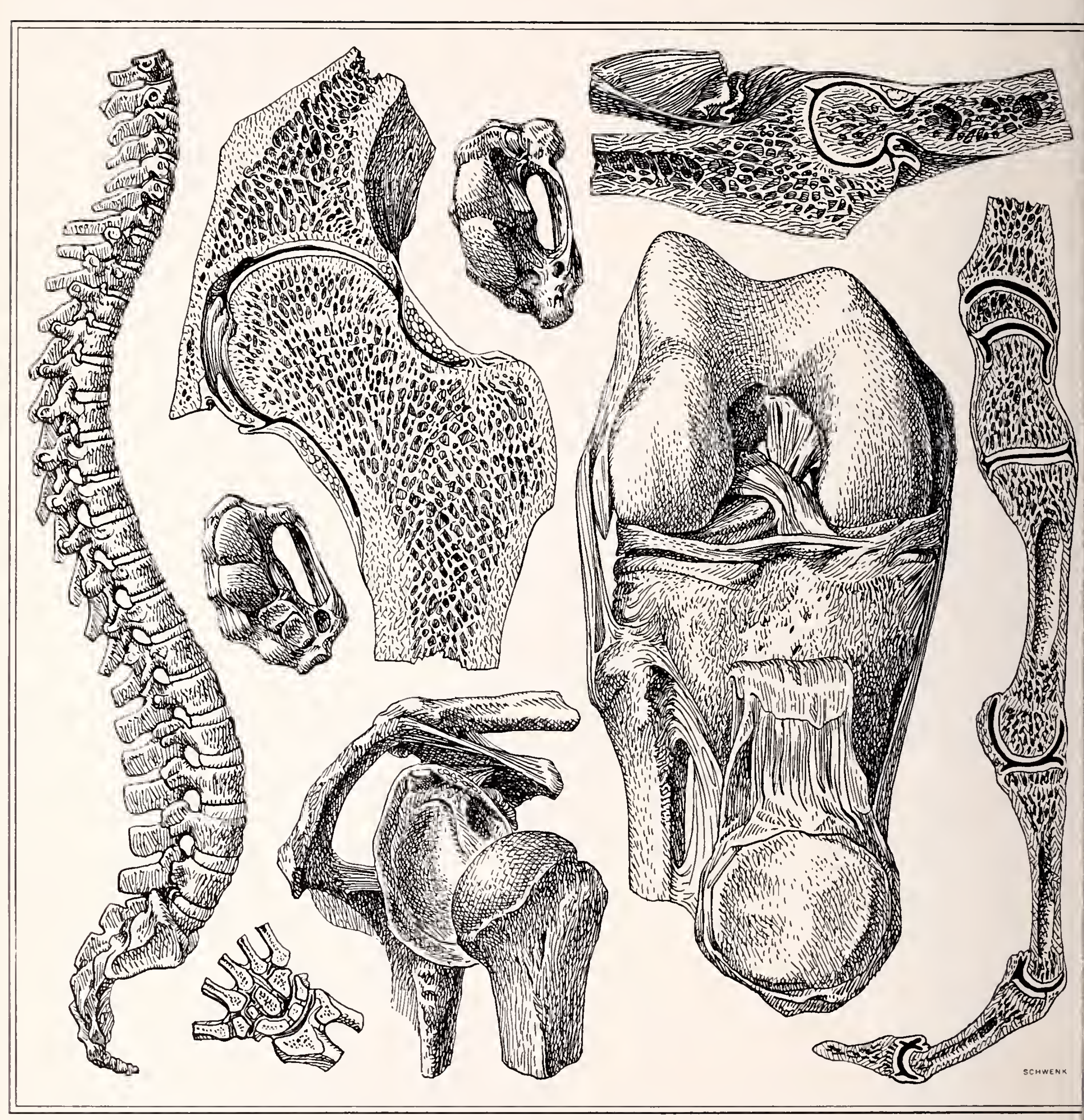
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IN THE BOOKS

GYNECOLOGIC AND OBSTETRIC PATHOLOGY: (Fifth Edition) by Edmund R. Novak, M.D., and J. Donald Woodruff, M.D.; published by W. B. Saunders Company, Philadelphia; pages 713; price, $16.

The first edition of *Gynecologic and Obstetric Pathology*, in 1940, by Emil Novak was one of the most important contributions to Gynecology in our time. This book was compiled by a brilliant mind who summarized his tremendous experience and interest in gross and microscopic pathology over a period of 30 years, and correlated his knowledge with the vast literature, in the early years largely of European origin.

A professionally prepared and revised text makes this book the continued standard in this specialized pathology and is of immeasurable value in the training of young physicians, particularly those most interested in Gynecology. It has provided a broad base of understanding and a scientific attitude toward both the investigations of our time and the care of patients. Through the subsequent editions, and now, this fifth edition edited by Edmund Novak and Donald Woodruff, the newer contributions to the literature have been assimilated and explained for our understanding.

This specialized study is of unusual interest because of the direct relation to development, reproduction, sex, the variations and effects of the hormones, and the unusual and numerous varieties of tumors that are so commonplace.

Throughout this book are numerous illustrations of microscopic and gross lesions, many of which are the best to be found. In the chapter on the Vulva particularly, newer aspects have been added since this is of especial interest to Woodruff. These include the granular-cell myoblastoma and the various dermatologic lesions of the vulvar skin.

Additional chapters by R.E.L. Nesbitt on Fertilization, Implantation, Placentation, Diseases of the Placenta, and the Pathology of Abortion, and also the one by John K. Frost on Cytopathology, complete this splendid book.

This continues to be the standard text and reference book in Gynecological and Obstetrical Pathology, and is recommended not only to the student, but the resident and the practitioner.

Laman A. Gray, M.D.

NARCOTICS AND NARCOTIC ADDICTION: (Second Edition) by David W. Maurer, Ph.D., and Victor H. Vogel, M.D., M.P.H.; published by Charles C. Thomas, Springfield, Illinois; pages, 339; price, $9.

In the second edition of the book *Narcotics and Narcotic Addiction*, Doctors Maurer and Vogel have presented the problem of addiction from many viewpoints, including that of the medical profession, the social scientist, law enforcement agencies and the addict himself. The causes and treatment of addiction are discussed, as well as the drugs causing addiction.

Most physicians will be confused, and may well be disturbed, however, at the inclusion of barbiturates and some non-barbiturate sedatives as well as stimulating drugs such as amphetamine in the class of addicting narcotics. While habitual users of these agents may present a picture at least similar to the narcotic addict, conventional pharmacologic classification as well as the federal and state narcotic laws have always separated these groups of drugs, and with good reason. On the other hand, if the authors intend their book to be an all-inclusive discussion of drug addiction, other agents should have been included, notably meprobamate and glutethimide.

While omitting discussion of the latter drugs when the literature contains numerous reports of "addiction" to them, the authors include a discussion of peyote, which they admit has not been responsible for a proven case of addiction. Its psychic effects make it apparently potentially addicting. Again, if the authors plan to discuss potentially addicting drugs, then why omit lysergic acid diethylamide, bufotenin, bulbocapnine and other psychotomimetic agents?

Physicians who use narcotic drugs in their daily practice will probably find it hard to agree with such statements as "medically, intravenous injection of an opiate is rarely indicated," or with the archaic idea that atropine will prevent the depressant action of morphine. The recommended treatment of acute barbiturate or narcotic intoxication with convulsant analeptics, nikethimide and inhalation of 95% oxygen with 5% carbon dioxide is also controversial, to say the least.

A final unhappy feature of the volume is the frequent misleading use of statistics. The reader is told in the first chapter that "there is no doubt that addiction is on the increase," but a graph on the facing page shows that while this statement was true in the years 1945-50, the number of addicts has decreased from about 60,000 in 1950 to about 45,000 in 1960. The same graph shows that the United States had nearly 200,000 addicts in 1920. While addiction remains a significant problem, the information presented by the authors simply does not support the idea that it is an increasing problem.

In addition to the statistical inconsistency, we are confronted with statistics that would look better in a newspaper headline than in a scientific work. We are told, for example, that 60-70% of thieves of all kinds in the United States are addicted, and we are presented with such unprovable figures as $100,000,000 for the total of street sales of narcotics in New York City in 1951! The authors apparently would like to convince the reader that bromide intoxication is a

serious problem, but a secondhand quotation from a 1935 textbook does not present a very convincing argument.

Statistics have a very significant and useful place in scientific literature, but they should be used in a scientific, rather than a journalistic, manner.

Despite these criticisms, *Narcotics and Narcotic Addiction* does contain useful material, even if it is of limited interest. All physicians could profit from the discussion of the many clever schemes used by addicts to obtain drugs under false pretenses from physicians. This reviewer found a section on the ritual of opium smoking and an extensive glossary of underworld narcotic terms completely fascinating. The chapters on identification of narcotic drugs by laboratory means, treatment of the addict, and the legal control of narcotics are well done and will be informative to physicians with sepcialized interests.

On the whole, however, *Narcotics and Narcotic Addiction* is not a book that a majority of physicians will want on their library shelves. It will prove of greater interest to workers in the social sciences than to the average physician.

Donald M. Thomas, M.D.

"In fact, beware of books. Some biologist has stated that if Nature could take her course unimpeded, the world would become populated with elephants wallowing about, knee-deep in a seething mass of mice. This man knew nothing of books. As a species they are imperishable, and against their multiplication Nature has no chance whatsoever. The time will come when every tree has been felled for paper, every calf for leather, and the few long-haired and ill-nourished people left in the world will be madly making card indices of the volumes which have filled every available cranny in which they can be stored. Laws will have been passed against their importation —only a quota of the French and German and Italian and Polish, especially Polish, books to be admitted each year. For should you happen to leave a pair of foreign books alone on a shelf in the state known as their original wrappers, they breed with astounding rapidity. Then, too, they have their diseases and are a trouble, like too many children. They have worms; they wear out their clothing, break their backs, dislocate their joints, and require the constant care of a bibliotherapeutist."—CUSHING, H.: *Consecratio Medici*, p. 263. Boston: Little, Brown & Company, 1940.

The sum of $15,000,000 has been voted by trustees of Loma Linda University, for construction of new facilities on both the Loma Linda and the Los Angeles campuses of the University. The major construction item is a new medical center for the Loma Linda campus which will include a 300-bed hospital with extensive outpatient, psychiatric and research facilities, according to University President Godfrey T. Anderson.

The Southwest Allergy Forum will meet at the Granada Hotel, San Antonio, Texas, April 21-23. Bernard T. Fein, M.D., is president and Boen Swinny, Sr., program chairman, both of San Antonio.

News Items

Harris Isbell, M.D., who specializes in clinical pharmacology and drug addiction, is now at the U. S. Public Health Service Hospital at Lexington, Ky., and with the University of Kentucky College of Medicine. Doctor Isbell is a 1934 graduate of Tulane University Medical School and interned at Charity Hospital, New Orleans. He was in residence training at the USPHS Hospital at Lexington from 1935-1936 and at Tulane, 1938-1939. He has been with the Public Health Service for 28 years and did research in drug addiction from 1944 to 1963.

Wendell R. Kingsolver, M.D., Carlisle, Ky., has gone to the Belgian Congo to spend six months in medical practice under the auspices of the Congo Protestant Relief Association. He is working in a hospital sponsored by the Methodist Church. Doctor Kingsolver was graduated in 1952 from the University of Michigan School of Medicine. In his absence, **Lloyd H. Pendergrass, M.D.**, who is associated with him, will maintain the Carlisle office.

Karl E. Yaple, M.D., Harlan, Ky., pediatrician was unanimously named "Jaycee of the Year" by the Harlan County Junior Chamber of Commerce January 28. He was cited for his chairmanship of the countywide mass immunization drive against polio conducted by the Harlan Jaycees. Doctor Yaple is a graduate of the University of Cincinnati Medical School.

Charles F. Wilson, M.D., Pikeville, and Mrs. Wilson spent the month of February in Haiti taking charge of an eye clinic. In 1962 they spent March at the Haiti clinic which is sponsored by Focus, an organization of nine eye specialists to provide this special medical care in areas where such care has heretofore been unavailable.

Richard E. Davis, M.D., Central City, Ky., was named Central City Man of the Year by the Central City *Messenger* and *Times-Argus*. Doctor Davis was cited for his work in the field of prevention and treatment of athletic injuries. He is chairman of the KSMA School Health Committee and is a 1946 graduate of the University of Louisville School of Medicine.

Joseph R. Bolton, M.D., Paris, Ky., surgeon, has moved to Brooksville, Fla., to practice in association with **Warren Clark, M.D.**, a fellow medical school student. Doctor Bolton has been in practice in Paris since July 1959. He was graduated from the University of Louisville School of Medicine in 1954.

Clyde T. Moore, M.D., Fern Creek, Ky., was elected chairman of the Jefferson County Board of Education January 7. Doctor Moore, a general practitioner and a 1945 graduate of the University of Louisville School of Medicine, has been a member of the Board since 1961.

Harold W. Owens, M.D., has started general practice at Irvington, Ky., in association with William D. Hatfield, M.D. Doctor Owens was graduated in 1961 from the University of Louisville School of Medicine and interned at St. Joseph Infirmary, Louisville.

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TB Groups To Meet April 25-26

The Kentucky Tuberculosis Association and the Kentucky Thoracic Society will hold their annual meetings at the University of Kentucky Medical Center at Lexington, April 25-26. The Thoracic Society will meet April 25. Jerome Cohn, M.D., assistant professor, Department of Medicine, U. of K., is program chairman for the Thoracic Society.

New KSMA Members Reported

The following new members have joined the Kentucky State Medical Association: D. C. Cameron, M.D., Owingsville; J. L. Chamberlain, M.D.; J. W. Rackley, M.D., and J. A. Shively, M.D. — all of Lexington.

New Office for Ky. TB Association

A new headquarters office building in Louisville for the Kentucky Tuberculosis Association is scheduled for completion this spring. It is located near District Two State Tuberculosis Hospital. Asa Barnes, M.D., and E. R. Gernert, M.D., both of Louisville, are serving on the building committee with Howard B. Hunt.

"There is more and more government interference in the conduct of one's private affairs; more and more tendency to want to rely on the government instead of doing it oneself; more and more whittling away at the private enterprise system; more and more feeling that business is irresponsible and the professional naive. The government's civilian payroll hit a record high of fourteen billion dollars in the last fiscal year, and the first month of the new fiscal year has shown an increase of 14,530 employees over the preceding month, for a total of 2,500,000 federal employees on the payroll." — Austin Smith, M.D., president, Pharmaceutical Manufacturers Association, to National Association of Chain Drugstores, October 25, 1962.

The year 1963 marks the 100th anniversary of the world Red Cross movement.

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TV Advisory Group Is Named

An advisory committee to the Kentucky Authority for Educational Television was approved by the Authority January 8. The committee, recommended by Governor Bert T. Combs and composed of representative Kentucky leaders, is headed by Richard Van Hoose, Jefferson County school superintendent. J. P. Sanford, KSMA executive secretary and managing editor of The Journal, is a member of the Committee.

Lynn P. Carmichael, M.D., Miami, Fla., general practitioner and a 1952 graduate of the University of Louisville School of Medicine, flew to Havana, Cuba, in February under the auspices of the American Red Cross, to work with the medical personnel accompanying Cuban refugees to this country.

Cathryn C. Handelman, M.D., Louisville pediatrician, has been named chairman of the new Kentucky Commission on Children and Youth. Doctor Handelman, a 1942 graduate of the University of Louisville School of Medicine, is a former director of maternal and child health for the State Health Department.

The ninth congress of the Pan-Pacific Surgical Association will be held November 5-13 at Honolulu, Hawaii, to be followed by the first Pan-Pacific Mobile Educational Lecture Seminar November 13-December 10 in New Zealand, Australia, Thailand, the Philippines, Hong Kong and Japan. For additional information, write: F. J. Pinkerton, M.D., director general, Pan-Pacific Surgical Association, Suite 236, Alexander Young Building, Honolulu 13, Hawaii.

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BUYERS GUIDE

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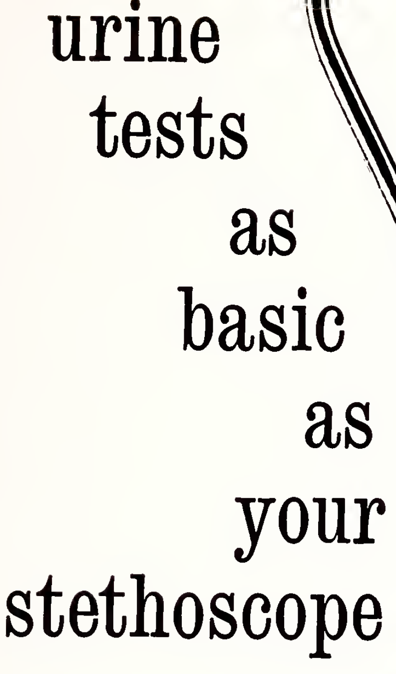

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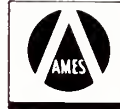

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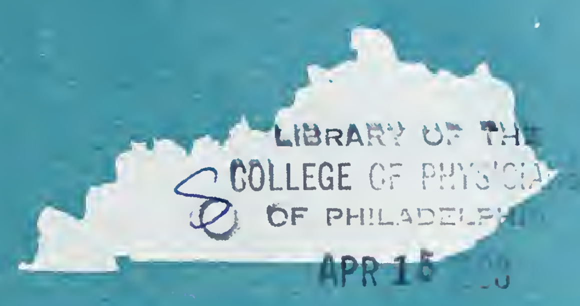
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in severe respiratory infections
refractory to other measures..

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(chloramphenicol, Parke-Davis)

for established
clinical efficacy against
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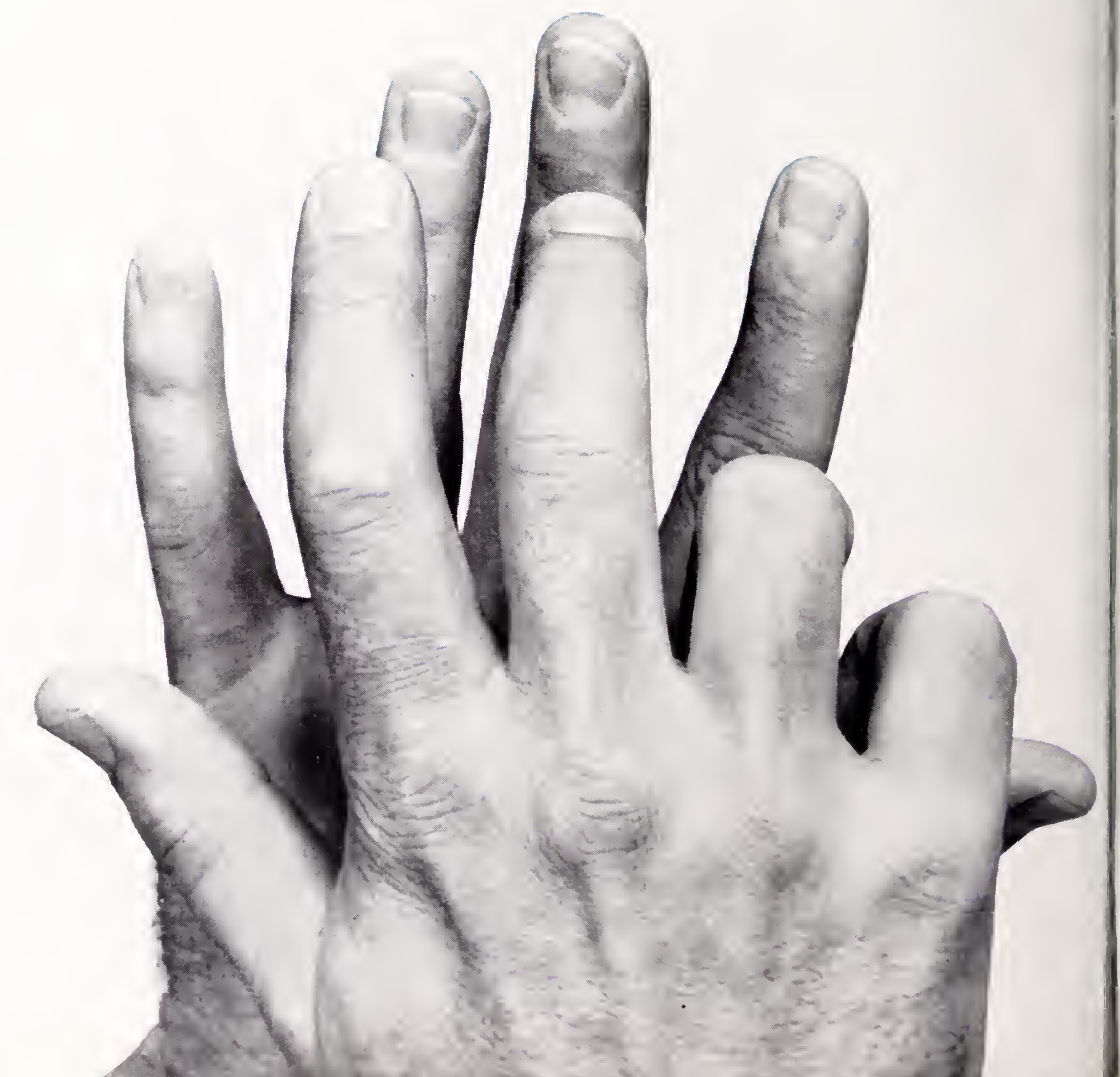

In Friedlander's Pneumonia[3,13]

Although the prognosis in Friedlander's pneumonia is poor, treatment with CHLOROMYCETIN has shown a good response when susceptible strains of *Klebsiella pneumoniae* are incriminated.

In *Hemophilus Influenzae* Pneumonia[3,4,13,14]

Because the invading organism is usually sensitive to CHLOROMYCETIN, this agent is generally effective in pneumonias caused by *H. influenzae.*

In Staphylococcal Pneumonia[1-8,13]

CHLOROMYCETIN continues to remain effective against many resistant strains of staphylococci, and—alone or in combination with other antibiotics—should be considered when other antistaphylococcal drugs are ineffective.

In Acute Epiglottitis[4,10,11]

This condition is most often caused by *H. influenzae,* most strains of which are sensitive to CHLOROMYCETIN. Therapy should be instituted at once, since the disease may progress from the first symptoms to a severe respiratory obstruction in four to six hours.

In Pneumonias Due to Gram-negative Bacilli[3]

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In Staphylococcal Empyema[12]

The infiltrating lesions of staphylococcal empyema are often difficult to eradicate. While CHLOROMYCETIN should only be used when the infection has been resistant to treatment with other antistaphylococcal drugs, therapy with CHLOROMYCETIN, in conjunction with surgical procedures, will often bring favorable results.

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Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Thacher, H. C., & Fishman, L.: *J. Maine M. A.* **52**:84, 1961. (2) Hopkins, E. W.: *Postgrad. Med.* **29**:451, 1961. (3) Hall, W. H.: *M. Clin. North America* **43**:191, 1959. (4) Krugman, S.: *Pediat. Clin. North America* **8**:1199, 1961. (5) Ede, S.; Davis, G. M., & Holmes, F. H.: *J.A.M.A.* **170**:638, 1959. (6) Wolfsohn, A. W.: *Connecticut Med.* **22**:769, 1958. (7) Calvy, G. L.: *New England J. Med.* **259**:532, 1958. (8) Hendren, W. H., III, & Haggerty, R. J.: *J.A.M.A.* **168**:6, 1958. (9) Cutts, M.: *Rhode Island M. J.* **43**:388, 1960. (10) Berman, W. E., & Holtzman, A. E.: *California Med.* **92**:339, 1960. (11) Vetto, R. R.: *J.A.M.A.* **173**:990, 1960. (12) Sia, C. C. J., & Brainard, S. C.: *Hawaii M. J.* **17**:339, 1958. (13) Rosenthal, I. M.: *GP* **17**:77 (March) 1958. (14) Gaisford, W.: *Brit. M. J.* **1**:230, 1959.

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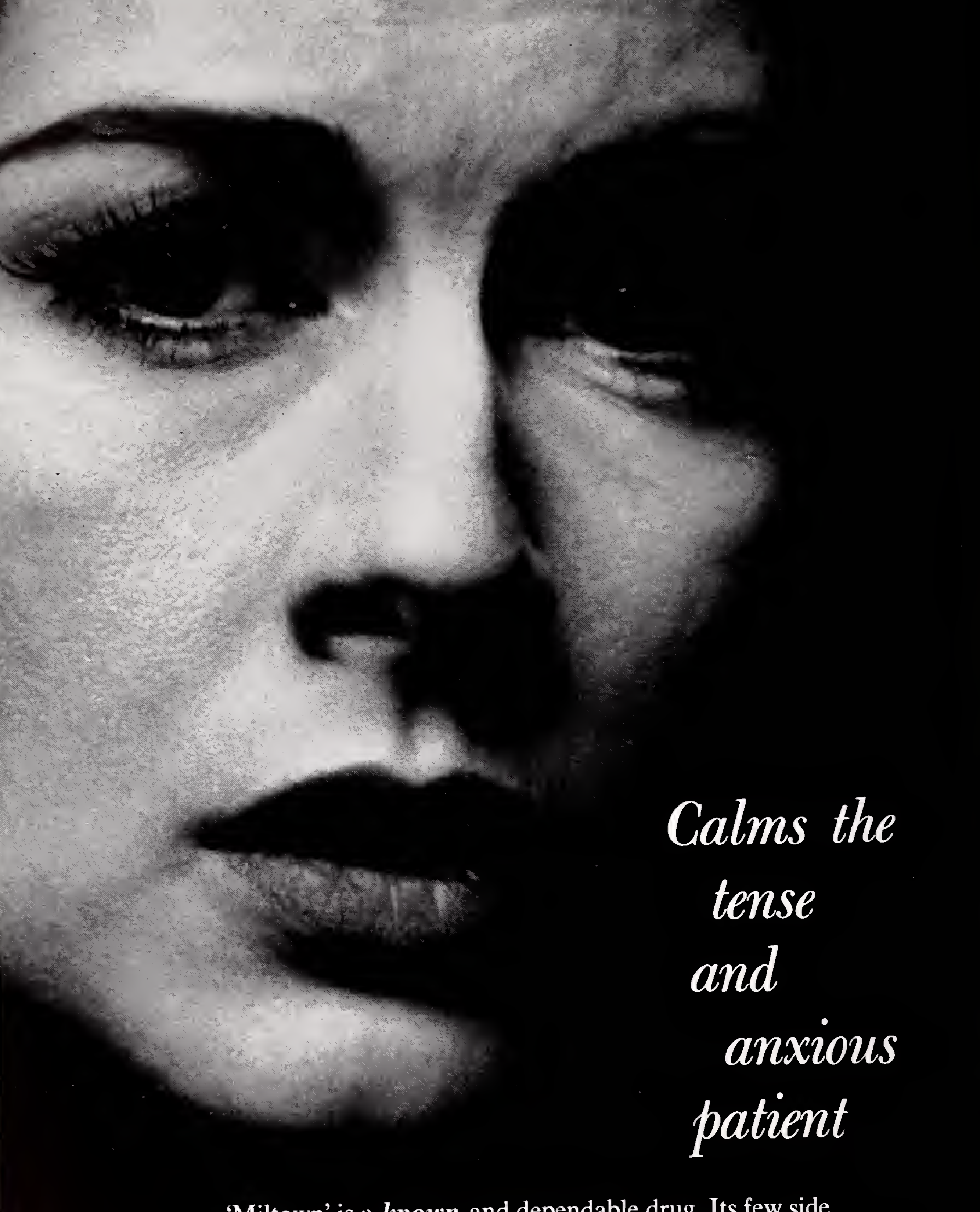

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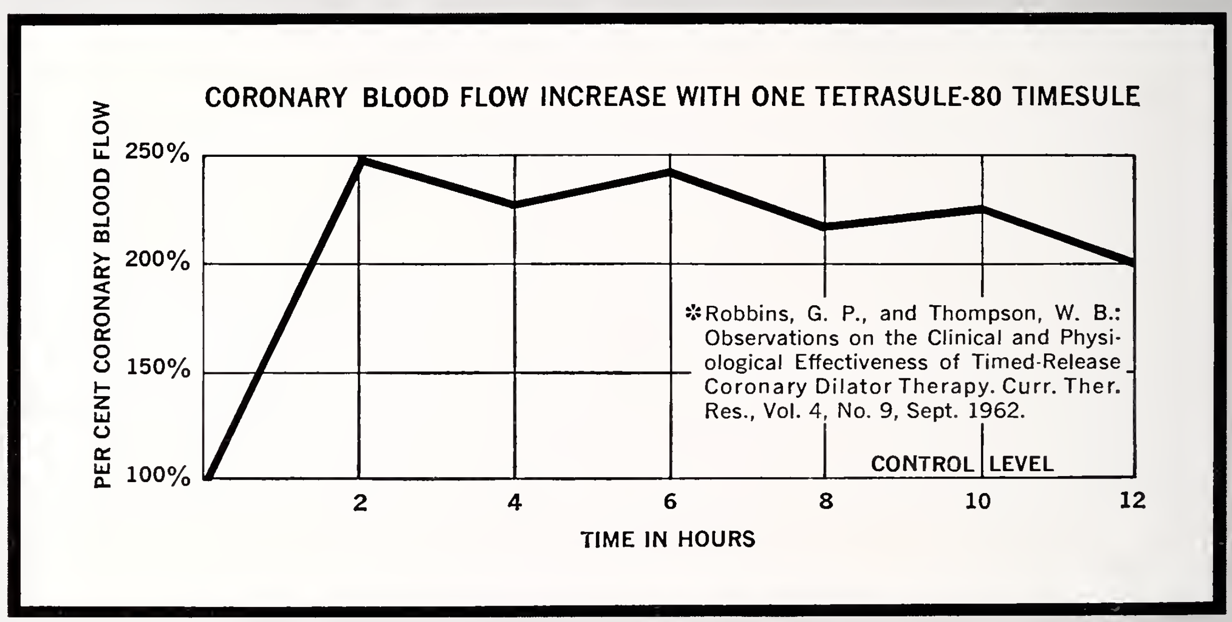

*Robbins, G. P., and Thompson, W. B.: Observations on the Clinical and Physiological Effectiveness of Timed-Release Coronary Dilator Therapy. Curr. Ther. Res., Vol. 4, No. 9, Sept. 1962.

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MESSAGE FROM THE PRESIDENT

The Spiraling Cost of Hospitalization*

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Much has been written and said about the abuse of hospitalization insurance, but is that the main problem in increasing the cost of the average patient's stay in the hospital? It is doubtful. A great many factors are involved.

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In the hospital in our small community a total of seven employees are paid to run the recently established drug department, and not one is a registered pharmacist Is this necessary and is it economical?

Is it necessary to order a blood urea nitrogen, creatinine, fasting blood sugar, cholesterol, total protein, albumin, globulin, protein bound iodine, sodium, potassium, chlorides, electrocardiogram and chest x-ray on a patient who had a fairly definite diagnosis when admitted to the hospital?

If we have any of the art of medicine left in us, let us use it more and use science as a very definite adjunct to it.

Hugh Mahaffey, M.D.
KSMA Vice President (Eastern)

*This is the second in a series of guest articles written at the request of David M. Cox, M.D., president of the Kentucky State Medical Association, by the vice presidents of KSMA and the president of the KSMA Woman's Auxiliary.

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1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

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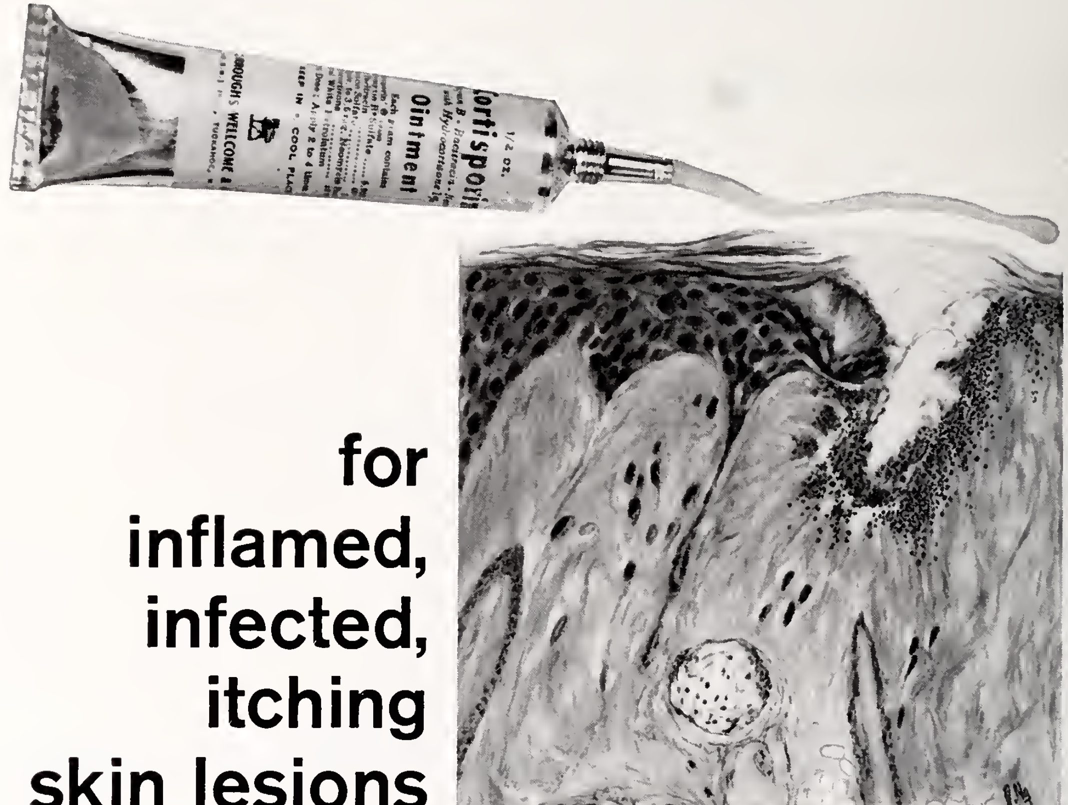

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2. Fluoride Compounds, Accepted Dental Remedies, 27th Ed.:139, 1962.

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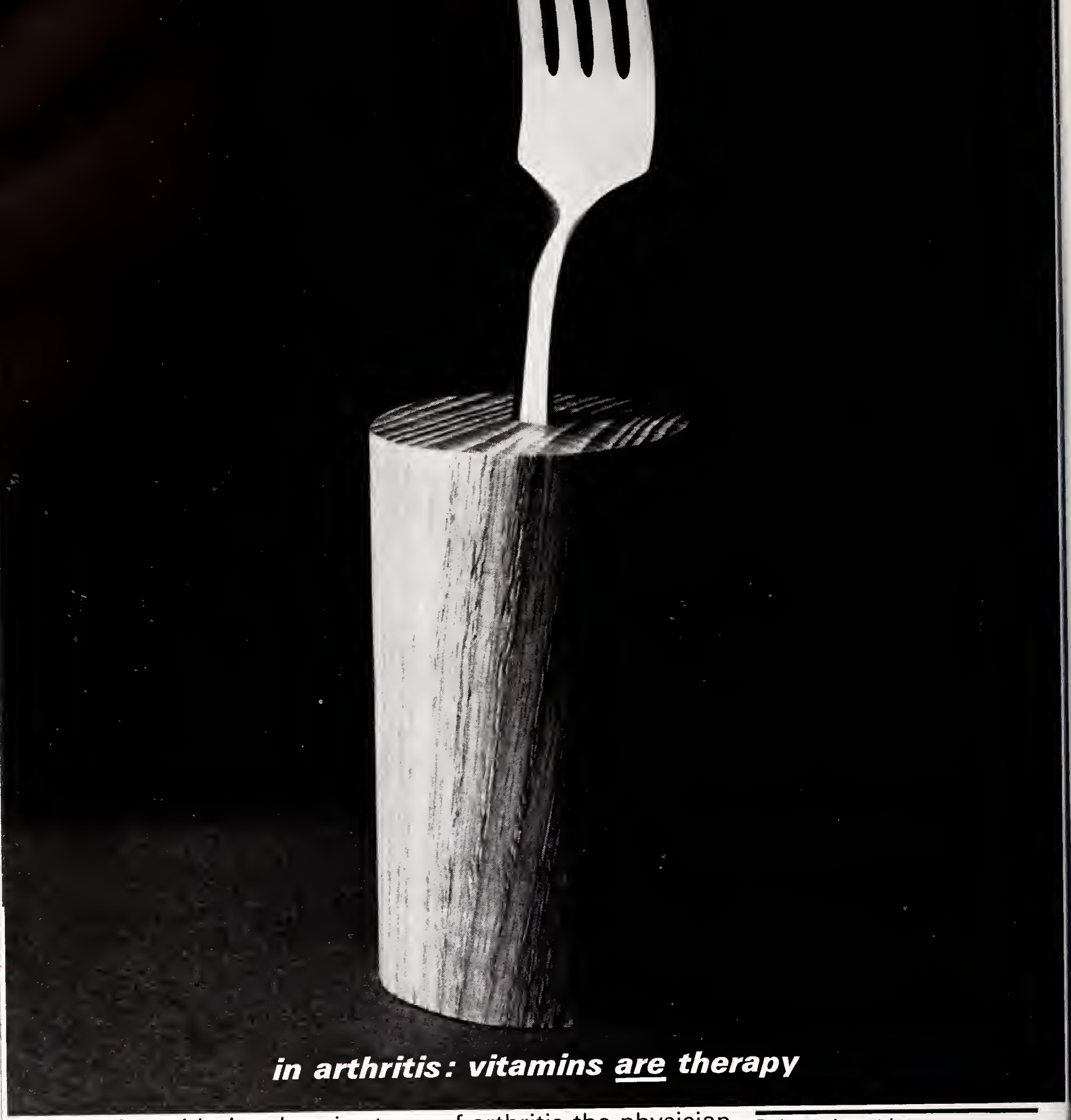

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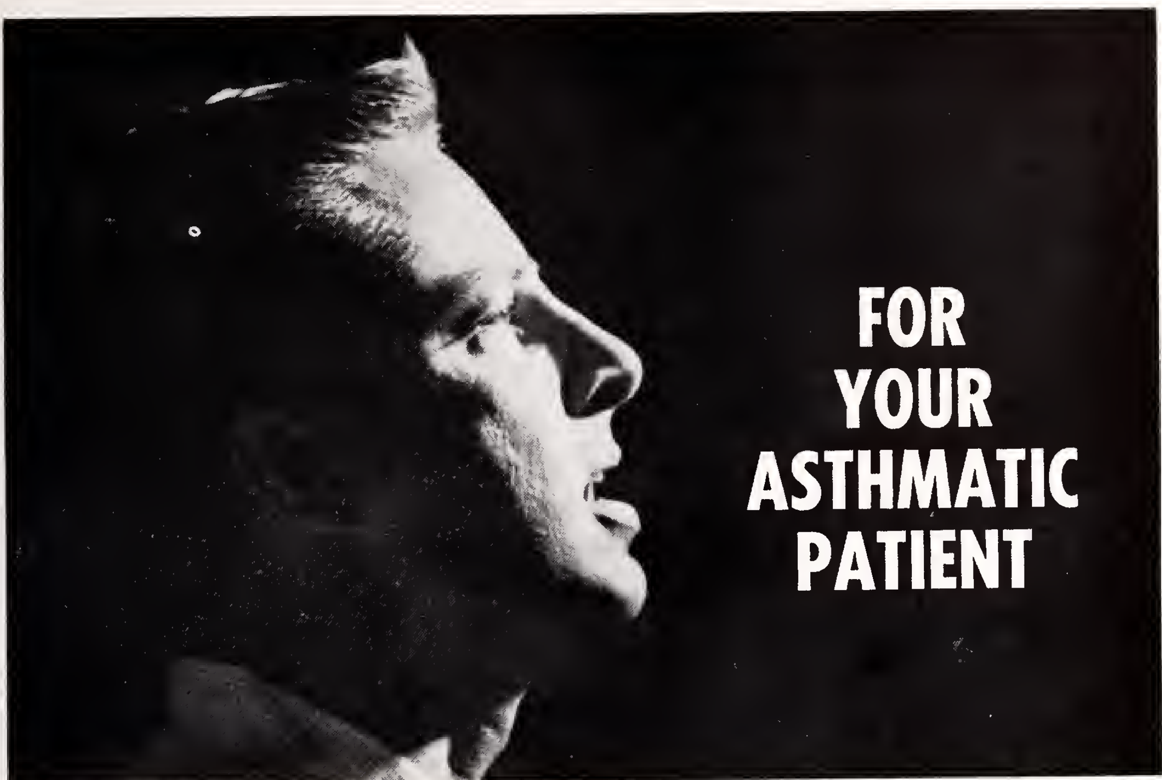

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THE INSURANCE PAGE

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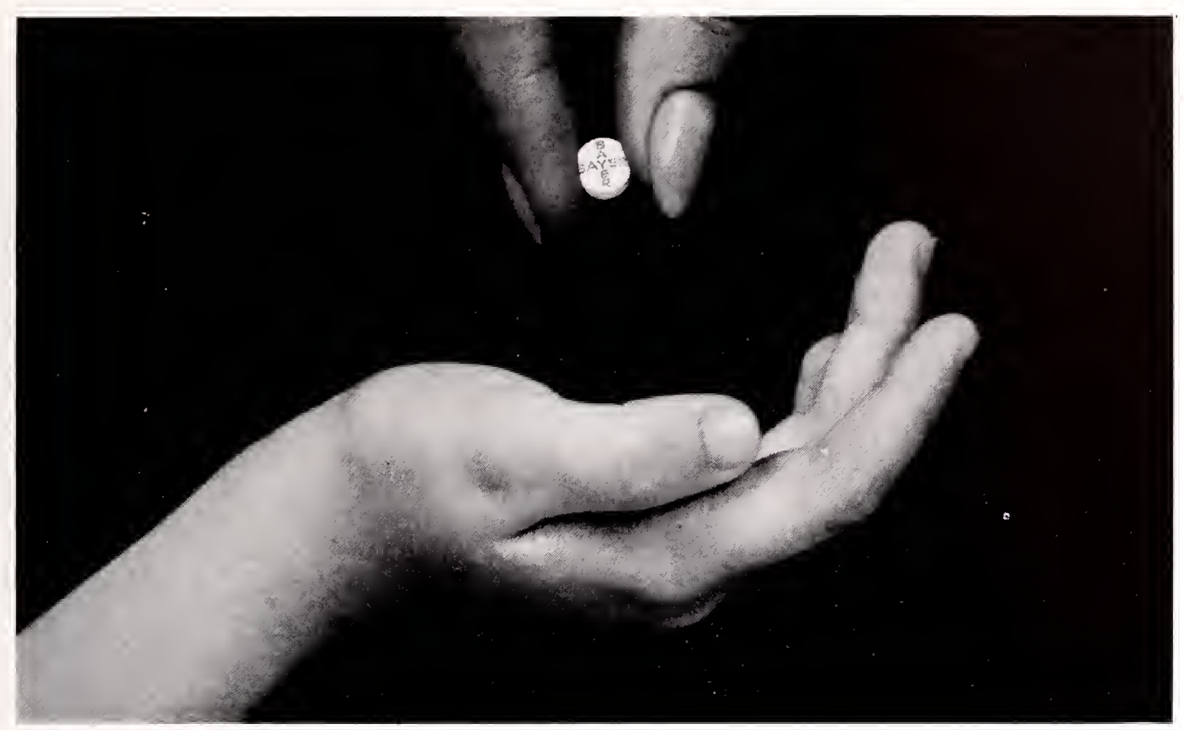

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IN THE BOOKS

OFFICE PROCEDURES: (Second Edition) by Paul Williamson, M.D.; published by W. B. Saunders Company, Philadelphia, 1962; pages, 448; price, $13.50.

This second edition of Doctor Williamson's book contains more information than the first, including chapters on Office Psychiatry and Geriatrics.

This reviewer felt it to be a great attempt to cover the entire field of office procedures for the general practitioner, and the author includes many "nuggets" which are quite practical. The style is certainly "earthy" and easy to read.

The diagrams are, at times, over-simplified to the point where they are impractical and confusing. Many references to the use of the paper clip as a retractor, probe, etc., make one feel that a subtitle ought to be "The Use of The Paper Clip in Office Procedures."

It was this reviewer's general impression that the book is a valuable adjunct only if the practitioner can visualize these procedures in actual practice. The hazard is that some practitioners may attempt some of these manipulations and techniques without having seen them done by physicians more adept at them.

Too many of the procedures involve minor surgery which is not too "minor," and is best left in the hands of specialists. This book, in short, overextends the realm of the general practitioner who himself seems to be overextended today anyhow except for those few rural physicians who are forced to attempt many procedures by necessity.

Doctor Williamson injects the wit and advice of a seasoned practitioner and provides the general physician who has seen or tried these procedures before with a good reference manual. I hope that few generalists will feel themselves capable of doing many of these procedures until they have performed them under the supervision of a qualified person.

Nicholas J. Pisacano, M.D.

PHYSICAL DIAGNOSIS: (Sixth Edition) by Ralph H. Major, M.D., and Mahlon H. Delp, M.D.; published by W. B. Saunders Co., Philadelphia, 1962; pages 355; price $7.50.

This textbook has evidently been found useful in medical schools, having gone through five editions since 1937. It is pleasant to read, quoting often from the sources where the pioneers of diagnosis recorded their discoveries. Students are thus led to recognize the vitality of the discipline, where each may yet find his new truths.

The portion of the work that deals with heart sounds is distinguished for its clarity. Most of the text is lucid and precise. But there are a good many inaccuracies, such as might confuse a solitary student. Some doubtful passages seem to be faults of proofreading.

The pictures are well-reproduced, with the exception of an x-ray on page 147, which is inverted. The illustrations display the author's extraordinary acquaintanceship with extreme illness. A few of them would be more valuable if colored.

At risk of favoring trade-school pedagogy, one may wish that Chapters 6, 7, and 8, on chest examination, might be organized so as to give the student more help in the difficult task of establishing his own agenda.

A section on chest x-rays, comparable to that on abdominal x-rays (page 264); a procedural sketch for vertigo, shock, low back pain, comparable to that on coma (page 309); descriptions of physical findings in syndromes of protruded intervertebral discs, phlebothrombosis, primary atypical pneumonia; all these one might wish for. And it is legitimate to wish for them. This book is full of information and good clear explanation. If it can be improved (without becoming costlier or heavier), it will be excellent indeed.

Austin Bloch, M.D.

LOUISIANA SWAMP DOCTOR—THE LIFE AND WRITINGS OF HENRY CLAY LEWIS: by John Q. Anderson; published by Louisiana State University Press, Baton Rouge, Louisiana; pages, 296; price, $5.

This book is in two parts. The first 70 pages is a well-documented biographical sketch of Henry Clay Lewis, M.D. (1825-50). The second part is comprised of "The Writings of Henry Clay Lewis" as edited by Professor Anderson. Twenty pages of footnotes (346 of them) add considerably to the value of the book and in themselves provide the reader with interesting material for further study. It is regrettable that the publishers have separated the footnotes from their proper location at the bottom of the page of text. An adequate index to both text and footnotes is provided.

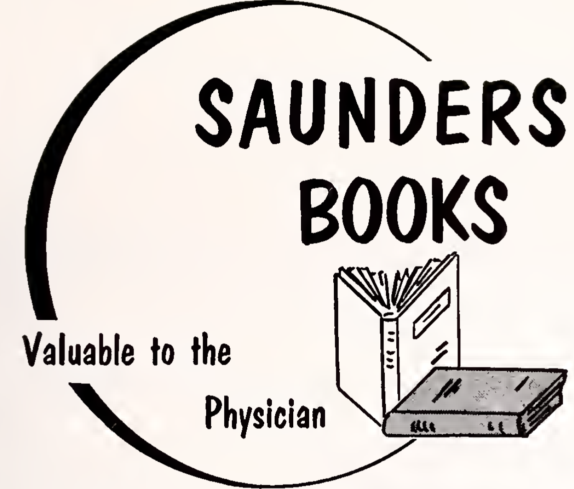
Professor Anderson is to be commended for his painstaking efforts to present the reader with an accurate biographical sketch of this obscure 19th Century medical practitioner, and for establishing beyond reasonable doubt that "Madison Tensas, M.D., Louisiana Swamp Doctor" was in real life, Henry Clay Lewis, M.D.

Kentucky physicians and historians may find some portions of Doctor Lewis' "semi-autobiographical" writings of particular interest for, after serving a medical "apprenticeship" in Yazoo City, Mississippi, he attended two sessions of lectures (1844-45, 1845-46) at the Louisville Medical Institute from which he graduated in 1846.

This reviewer thoroughly enjoyed both parts of the book. Readers interested in Mid-nineteenth Century American folk lore and humor will find much of interest among these pages.

Professor Anderson has fortunately chosen to re-

(Continued on page 364)



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1. Borota, A., and Grinell, R. N.: J. Amer. Geriatrics Soc., 10:413, 1962. 2. Spoor, H. J.: N. Y. State J. M., 58: 3292, 1958. 3. Lubowe, I. I.: Western Med., 1:45, 1960. 4. Weissberg, G.: Clin. Med., 7:1161, 1960. 5. Lieberman, W.: Amer. J. Proctology, 12:374, 1961. 6. Dick, L. A.: Skin, 1:341, 1962.

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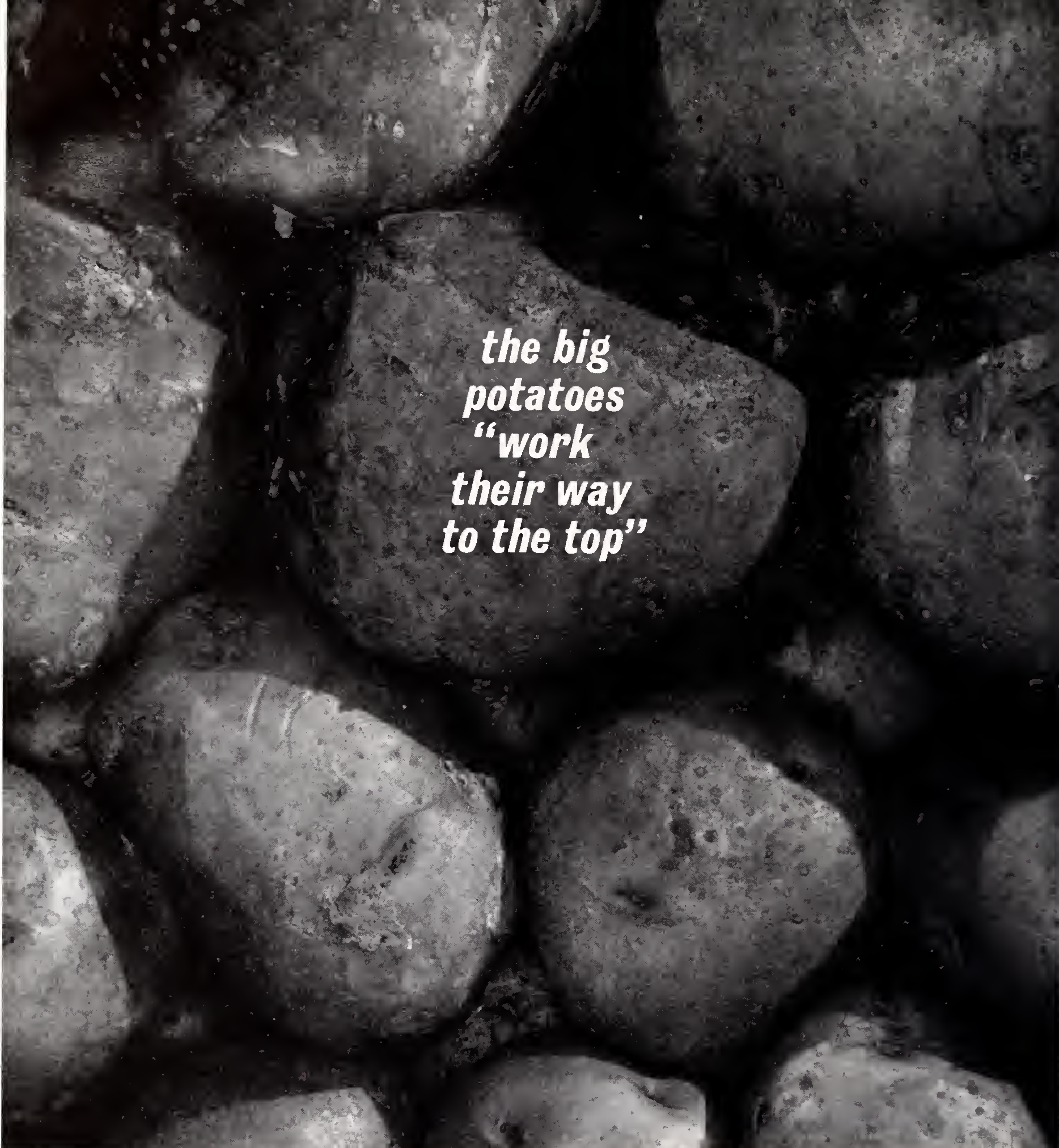

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VOLUME 61 APRIL, 1963 No. 4

A Prescription for the Alleviation of Welfare Abuses and Illegitimacy*

H. CURTIS WOOD, JR., M.D.*
Philadelphia, Pa.

Control is the answer to the problem of rapid population growth. Irresponsible parenthood is compounding our welfare and illegitimacy problems and physicians can help by offering fertility control information to their patients in suitable cases.

THE use of the word "prescription" suggests a state of illness for which a remedy is needed. Individuals may be sick or societies and nations may be sick, in the broader sense of the word. There is much evidence that both our country and the world are not in a very robust state of health or wellbeing.

Doctor Gregg, of the Rockefeller Foundation, has said, "The world may be thought of as having cancer and people are the cancer cells, growing in an uncontrolled and destructive manner." The prescription for this type of world cancer is population control, but the difficulty seems to lie in getting the prescription filled and to the patient in time to obtain a cure.

Joseph M. Jones, in his booklet, "Does Overpopulation Mean Poverty?", states, "The problem of rapid population growth will not be ignored, for it is like a volcano erupting on a plain—building a towering mountain before our very eyes. It has erupted because modern science has suddenly in our generation brought the world 'death control.' It will continue to erupt, and the mountain will continue to grow, until man's will and man's conscience combine with modern science to bring population growth under comparable control. There is no time to be lost, for unless action is taken promptly, the problem of a geometrically increasing world population may soon grow beyond control. It is spreading its dominion over human affairs and in many parts of the world it is already frustrating man's prospects for self-fulfillment."

Albert Einstein, one of the most intelligent men of the century, places the responsibility more squarely upon the medical profession in his statement, "Progress of hygiene and medicine has completely altered the earlier precarious equilibrium of the quantitative stability of the human race. I am therefore firmly convinced that a powerful attempt to solve this tremendous problem is of urgent necessity."

Some attempts are being made by a relative few dedicated and far seeing people. The United States Government continues to avoid the basic relationship between excessive population increases and depressed living standards and starvation and seems determined to foreign aid this country into bankruptcy without substantially improving the lot of those in the depressed areas. The medical profession continues on the traditional path of lowering death rates all over the world, now trying hard to

Presented at the meeting of the Kentucky Obstetrical and Gynecological Society September 18 during the Annual Meeting of the Kentucky State Medical Association at Louisville, September 18-20, 1962.

eliminate malaria—one of Nature's greatest checks on excessive fertility—and hides its head in the sand in an attempt not to see the other half of the equation or any obligation to balance birth rates to the declining death rates.

Medical Apathy

There are good reasons why so many medical men are psychologically and philosophically apathetic toward fertility control. Doctors are conservative by nature and any radical changes in point of view are only slowly accepted. This is proper as long as conservatism does not prevent growth and expansion. The Rev. Fosdick's concept that "indiscriminate human spawning serves no useful purpose" still seems shocking and radical to the ultra-conservative.

Thirty years ago I was one of a group of young physicians making ward rounds with an eminent professor of obstetrics and gynecology in one of our largest medical schools. We came to a patient who was obviously exhausted in body and mind from too frequent child bearing and who could ill afford to raise the newest addition to her already large number of children. One of the group asked the professor as to the advisability of offering this woman a sterilization procedure. His reply was, "Gentlemen, it is not in the province of the physician to attempt to ameliorate economic and social ills by means of the scalpel." This was a somewhat verbose way of saying that doctors should stick to their healing and not become involved with problems unrelated to sickness. Many physicians still have this philosophy, to which, of course, they are entitled, but there is a trend for medical men to become more active in all kinds of social, economic, community and even political matters. In my opinion this is not only a good thing, it is absolutely essential.

Times have changed and medical attitudes must also change. There is too much at stake for ourselves, our children and humanity for the medical profession to continue ignoring these problems. How can any rational and intelligent person fail to realize that much of the suffering and misery in the world today stems from medical advances as related to reduction of death rates and that we therefore have a responsibility and even an obligation to help in any way we can to ameliorate these economic and social ills? Are welfare abuses and illegitimacy serious enough problems to warrant the attention and effort of medical men? I believe they are.

The welfare problem is related to socialism, security and freedom. The people who established this country, from the Pilgrims to the Forty Niners, had such a dedication toward freedom that they were willing to live under circumstances that afforded almost no security. Their emphasis was often different, one group was determined to worship as they saw fit while the other was more interested in freedom to use their six shooters. There was plenty of freedom, no security and only a little welfare. If a man was unable to take care of himself, or of his family, he did not long survive. We have advanced far along the road to the Welfare State and our dearly won freedoms have gradually been regulated, modified or eliminated. The medical profession has stood aloof while these changes were taking place and it is only recently that there has been concerted and organized action by the doctors to protect their freedom to practice without governmental interference. Perhaps we have waited too long.

In December 1961, Abraham Ribicoff, the then Secretary of Health, Education and Welfare, said there were 7,250,000 persons in the United States on some kind of relief or welfare aid and that the problem cannot be solved by government alone. One wonders what other methods of solution he might have had in mind.

On April 14, 1962, the Conference on Economic Progress claimed that more than 77,000,000 Americans or more than 2/5 of the Nation, lived in poverty or deprivation in 1960. Their report went on to say, "Our economic growth during the past nine years has been little better than half the needed rate and small progress has been made toward solving what President Kennedy has called the major domestic problem for the 1960's—to prevent technology and automation from continuing to cause increased unemployment and idle plants." If 2/5 of the people in America are now living economically substandard existences what will be the situation by the year 2000—only a scant 38 years away—when our population will probably have doubled and be around 400,000,000? Many of us shrug such a question off with the remark, "Oh, I don't worry about that because I will not be around by then." But our children will be—if

spared an atomic holocaust—and our grandchildren. Is it fair to them to ignore this ever increasing problem?

Welfare Trends

In March 1962 the Chicago Daily News contained this item: "The burgeoning cost of public assistance in a time of unprecedented prosperity clearly calls for drastic measures. Somehow, the trend has to be reversed or the productive portion of society will be dragged down by the burden of supporting the unproductive." What is the trend that has to be reversed and how can it be? William Vogt, in his excellent book, "People," tells us that by the year 1965—if present rates continue—half the babies born in the Metropolitan New York area will be born to indigent families on relief. That is the trend. The recipients of welfare funds are outbreeding the taxpayers who supply the money.

In 1960, 830 million tax dollars went to support unwanted or inadequately cared for children in the United States. This figure, incidentally, is nearly four times the amount that was spent by the U. S. State Department in the same year. Support of dependent, neglected and delinquent children in Philadelphia was just under $25,000,000 in 1959, which amounted to $23 for every Philadelphia taxpayer. The alarming thing is the way these figures are growing. From 1938 to 1960 the number of these unfortunate children in Philadelphia, who exist on public charity, grew from 9,800 to over 56,000 and there is a tendency for these figures to double every 10 years. The states are finding it increasingly difficult to meet these huge bills and are asking for more and more federal help, which has more than doubled in the past 10 years. In 1953 federal aid to states was about $4,000,000,000 while the 1962 figure will approximate $10,000,000,000. Old Age Assistance, Unemployment Compensation and Work Programs in depressed areas are going to require increasingly huge amounts of tax dollars—$900,000,000 has just been appropriated—and it is difficult to see any realistic escape from an ever greater tax burden for our descendants. Fertility control or voluntary, responsible parenthood can, however, make a substantial contribution in these areas.

For example, let us take two mythical and non-existent families and call them Smith and Jones. Mr. Smith is an educated and hard working citizen who supports his wife and three children and pays taxes. Mr. Jones might be described in the socially acceptable term as "unfortunate," which means he never had the advantage of a good background, adequate education or any special abilities which might have made it possible for him to support himself, his wife and 10 children. His various brief periods of employment did not provide nearly as much money as was needed for his large family nor as much as they received by going on relief.

Let us now make a big assumption and say that the Smiths were a three-child family and the Jones a 10-child family, each continuing in this pattern for two generations. Under such circumstances Mr. Smith would have 27 great grandchildren who would have to work hard and pay taxes to support the 1,000 great grandchildren of the unfortunate Mr. Jones. There are many inadequacies in such an over-simplification of the problem such as a few worthless alcoholics turning up in the Smith family and a President of the United States or a second Ben Franklin appearing in the Jones line, but I feel it does illustrate how rapidly those on welfare may outnumber those who feed them. There are also many who feel that intelligence is strongly hereditary and that there is an alarming fall in our national intelligence level for these same reasons.

Our Declaration of Independence tells us that we are endowed by our Creator with certain inalienable rights which include life, liberty and the pursuit of happiness. How much happiness does the 2/5 of our population that live in poverty and deprivation enjoy? Are our 7,250,000 unemployed pursuing much in the way of happiness? We have a very basic and a very simple question that needs to be answered. As a part of their right to pursue happiness, as a means of exercising some of their freedoms of choice do Americans have the privilege of deciding how many children they wish to have? Do they also have the freedom and the right to choose the method they will use?

I saw a poster in a trolley car in Philadelphia picturing a housing development with the words, "Support every citizen's right to buy the home of his choice regardless of race, religion or nationality." It was signed by the Commis-

sion on Human Relations. Would this Commission also support the right of every married couple to fill the home of their choice with the number of children of their choice? The Smiths planned their family of three and few would criticize them for doing so. No doubt the obstetrician or their family doctor helped them to regulate their fertility to the desired number. Did the Joneses, struggling along on relief, want to compound their problems to a total of 10 children? Probably not, but they were too ignorant, uneducated, shiftless or irresponsible to do anything about it.

For 25 years I have seen these Mrs. Jones type of patients in the maternity pre-natal clinics in various hospitals, registering for their third to tenth pregnancy. I would usually ask them if they wanted to have any more children subsequent to the present pregnancy and they would reply with varying degrees of profanity that they had not wanted the last four, five or six, etc. Then the woman would be told that as a *great favor to her* we might be able to fix her so that she would never have any more children. It is very important to spend a few minutes in explaining the details of a postpartum tubal section and to stress that no organs are removed, that she will still menstruate, not "lose her nature" and will not know that anything has been done except that she will never have to worry about getting pregnant again. The patient is told that the operation will be done the day after delivery, barring any serious complications, that it only takes about 20 minutes, that she will feel no pain during it and should be able to go home on her fourth or fifth day. Many declare this to be the best news they have heard in years. I have never had any woman offended or upset because of offering her a sterilization but there have been some who could not accept it because of their religious beliefs. Over the years it has been surprising how many have not allowed their religion to take precedence over their desire to avoid future pregnancies so the particular denomination or type of religion should not prevent a physician from suggesting the procedure.

Aspects of Control

There are very few people who object to the basic principle of voluntary, responsible parenthood. They agree that a child's first birthright is to be wanted and that couples should be allowed to plan the size of their families. Contention arises mostly because of differences of opinion as to the methods to be used. We recognize that there must be different methods of fertility control for individual couples and endorse the physiological, chemical or mechanical techniques. Many welfare recipients are unable to effectively use any but the surgical method with the possibility that the new, plastic-uterine ring may in the future become the method of choice for such patients. Selection of suitable techniques is a medical problem and must be solved by cooperation between the physician and the patient.

In the past two and one-half years the Human Betterment Association has received over 3,000 requests for help from men and women who wish to terminate their fertility. These have come from every state in the union, representing a wide cross-section of the population. Some are on relief and state that they feel it is unfair and unwise to have more children than they can care for while others may be from the high income bracket who have never found a satisfactory contraceptive. A few examples:

1. A woman about to undergo her sixth Caesarean section, in poor general condition, most anxious to avoid any more operations and told by her doctor that because of local regulations he is not permitted to cut her tubes.

2. Many women on relief with up to 10 or more children who have gone from clinic to clinic begging for sterilization and told it cannot be done. One such was an epileptic who had as many as 20 seizures in 24 hours when she was pregnant.

3. Patients with all manner of gynecological complaints, from excessive bleeding to prolapse, who are refused help in the form of an hysterectomy which would solve both their medical problem and anxiety as to unwanted future pregnancies.

4. Frequently the reports indicate sympathetic doctors who say they would like to cooperate but cannot do so because of hospital rules, County Medical Society regulations or because they fear repercussions from the Accreditation Commission, the AMA, the College of Physicians or even the district attorney.

Rules can be changed and most of the fears are groundless, as far as voluntary sterilization is concerned. Only three states—Connecticut,

Kansas and Utah—have laws which prohibit even voluntary sterilization except for so called "medical necessity." This is a vague term and might quite properly include psychiatric as well as strictly physical indications. There are no legal restrictions on non-therapeutic voluntary sterilizations in the other states and on July 15, 1962, a new statute, legalizing voluntary sterilization, became effective in Virginia. This law requires the written approval of two physicians, the patient and the spouse—if any. A 30-day waiting period is required between the decision and the operation, which must be performed in an accredited hospital. It is to be hoped that other states will follow the example of Virginia so that physicians will feel free to perform sterilizations for socio-economic indications without uncertainty as to their legal status.

The Accreditation Commission has stated in writing that their only concern in the sterilization controversy is that each hospital establish its own rules in the matter and then abide by these rules. Whether the rules are liberal or conservative is not in their jurisdiction.

The Legal Council of the AMA has no fixed policy about voluntary sterilization but advises against the non-therapeutic variety because of possible legal difficulties in some areas.

We see, then, that in most hospitals the doctors may write their own tickets, as far as voluntary sterilization is concerned. All that is needed is a little courage and perseverance. It is best to have a sterilization committee appointed of not more than five physicians and allow a majority vote to decide the issue. A properly worded and easily understood legal release should be signed by the patient and spouse or guardian in the case of a minor. With a few precautions and a common sense approach there is nothing to fear and if all over the country voluntary sterilization were offered to indigent patients more could be accomplished in the reduction of welfare abuses in the future than could be achieved by any other one method.

Illegitimacy involves too many problems of a moral, social, economic and philosophical nature to be discussed other than very briefly here. It is widespread and one out of every 20 babies born in the United States is illegitimate. The District of Columbia has the highest rate in the country with one out of every five babies born. About 200,000 illegitimate babies are born every year in this country.

How does one inculcate higher moral standards in the young? We have no simple prescription to offer for the young, unmarried girl who gets into trouble. This type of case is an individual and family problem but is not of public concern. Our prescription is intended for places like Cook County, Ill., where there are 140,000 children in families on relief. The fathers frequently disappear and leave the mother to bring up the children as best she can on limited funds. Forty-seven per cent of these 140,000 children—nearly half—are illegitimate and probably a much higher percentage were unplanned and unwanted by their parents. The economic and social problems that develop from this type of environment are legion.

One unmarried woman in Philadelphia, who had been on relief all her life, produced 11 illegitimate babies over a 12-year period. She had these children in the free wards of hospitals at taxpayers' expense and undoubtedly would have been delighted to sign the sterilization papers after two or three, but no social worker, nurse or doctor ever suggested it. Is this fair to the community, the patient or the poor children who are condemned to a miserable existence under sub-standard conditions? Much of her welfare money was spent in ubiquitous tap rooms. We are convinced that very few women on relief deliberately have new models every year because of the slight increase in the size of their check with each additional baby. If offered sterilization the worst that could happen would be the patient's refusal, so why not? Most would welcome the procedure.

Summary

Involuntary, irresponsible parenthood is compounding our welfare and illegitimacy problems. Physicians should recognize the seriousness of this problem and offer fertility control to their patients in suitable cases. In areas where there are restrictive regulations in this regard the doctors should make an organized stand in favor of their right to practice medicine as they see fit for the mental, physical and spiritual benefit of their patients. Governmental hand-outs and welfare systems cannot solve this ever-increasing threat to our way of life without the active cooperation and assistance of the medical profession.

Pregnancy and Heart Disease*

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With careful medical management, most women with heart disease can bear children. Interruption of pregnancy or sterilization because of heart disease is rarely, if ever, indicated.

IT HAS been established beyond doubt that pregnancy increases the work of the heart. Studies have shown that in the normal woman the pulse rate increases and the total blood volume, particularly the plasma volume, increases about 30 to 50%. The area occupied by the cardiac silhouette on chest x-ray increases slightly and tends to show a "mitral configuration." The cardiac output increases up to 50%, beginning at about 10 weeks and reaching maximum value about the seventh-eighth month of pregnancy. Following this, there is a slight decrease in cardiac output. Then comes the added stress of the delivery, but the changes do not end here. The patient with heart disease must be ambulated more slowly and observed carefully during the first week post partum, because of sodium retention and other changes that occur during this period.

Seventy-five years ago, there was a French dictum that a woman with heart disease should not marry and if she did marry she was not to have any children. If she was delivered, she was advised not to nurse the child. Probably none of these statements should be made today. Even in 1900, reports from the literature indicated a 50% mortality for pregnant women with heart disease. This figure is probably too high as only the most severe cardiac abnormalities were detected. Better management has greatly reduced this figure.

Mortality

As a cause of death among pregnant women, heart disease ranks fourth, following hemorrhage, anesthesia and toxemia. Proper management greatly reduces the mortality. Although one-fourth of pregnant women have symptoms suggestive of heart disease such as dyspnea and edema, most series have shown heart disease to be present in about 2% of them. The mortality in the patient with heart disease is said to be about five times that of a patient with a normal heart, but the mortality in the good risk cardiac patient is only slightly above normal. Poor risk patients include those with active rheumatic fever, aortic lesions, those with congestive heart failure prior to pregnancy and those over 35 years of age. It has been stated that it is safer for a patient with heart disease to deliver at Margaret Haag Hospital than to have a normal heart and be delivered in some other hospitals.

Arteriosclerotic heart disease is rare in the child bearing woman. Our experience has been limited to three patients. Some studies have shown that congenital heart disease makes up about 5% of heart disease in pregnancy. In general, these seem to do well. Those with severe cyanosis have a much greater tendency to abortion. Rheumatic heart disease makes up about 90% of the cases of heart disease in pregnancy and it has been estimated that two-thirds of these have mitral stenosis.

6,000 Deliveries

During the last four years, we have been fortunate in being able to work with the same obstetrician (Lieutenant Colonel D. J. Summerson, MC, US Army) for one year at Ireland Army Hospital, Fort Knox, and three years at Tripler General Hospital in Honolulu. In his service there have been more than 6,000 deliveries during this period. There has been no maternal death due to heart disease and no pregnancies have been interrupted. Most women have not been advised against pregnancy, but we must admit there are a few that we did not encourage to become pregnant. This method of management is not dic-

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tated by religious belief. There has been only one infant death (a patient with a "reverse ductus") in the group that we have followed. There was one maternal death due to fulminating Lupus Erythematosus, as a lone example of any cardiovascular disease.

This record has been achieved by establishment of a combined Obstetrical-Cardiac Clinic. At the time of the initial visit to the Obstetrical Clinic, careful examination is performed. Those with a history of heart disease and those in whom the obstetrician finds a murmur are referred for cardiac evaluation. Many of these patients are considered to have the innocent murmur of pregnancy, particularly a pulmonary systolic murmur and in some cases an apical systolic murmur. If the diagnosis of heart disease seems proper, these patients are followed in the combined "OB-Cardiac Clinic" which meets one afternoon a week. This clinic is under the supervision of the Chief of Obstetrics and the Chief of Cardiology.

The management of the patients in the OB-Cardiac Clinic consists first of the maximum joint effort of both the obstetrician and his internal medicine colleague. The frequency of visits is ordinarily the same as those receiving routine prenatal care. As a prophylactic measure, a low salt diet is prescribed for all. Also, very strenuous activity is avoided, but routine house work is usually allowed. If congestive heart failure develops, the treatment is the same as in the non-pregnant state, using such measures as rest, digitalis and diuretics. In the most severe cases, hospitalization in the last half of pregnancy has been carried out. The route of delivery is determined by the obstetrician. We feel that there is no cardiovascular reason for Cesarean section. Some reports have suggested that one exception to this condition would be coarctation of the aorta, but this condition is rare. All patients with heart disease are given antibiotics, most commonly penicillin and frequently streptomycin is added because of the possibility of colon bacillus infection. We have encountered no cases of bacterial endocarditis where this prophylactic regimen was carried out.

Summary

Sterilization is rarely indicated in the woman with heart disease. More appropriately the heart disease should be properly treated. One of my "Chiefs" once wrote in a consultation that the treatment of severe mitral stenosis is commissurotomy, not tubal ligation. Interruption of pregnancy should rarely, if ever, be performed. There is no conclusive evidence that pregnancy causes any permanent damage to the heart. The physician should advise the patient with heart disease that there is an increased risk but that with proper management she can deliver a normal child.

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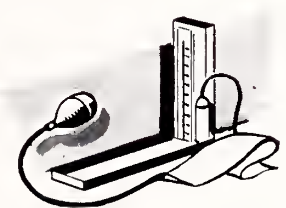

Thoracic Emergencies: Medical Aspects*

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Several thoracic symptoms, pain, dyspnea and hemoptysis, bring patients for emergency consultation. Prompt evaluation may lead to reassurance but in some cases timely, specific emergency measures may be life-saving.

THERE are three symptoms or signs related to the thorax which, when they occur suddenly, cause the patient to seek prompt medical attention. These are pain, dyspnea, and hemoptysis. Often the underlying condition presents no emergency, but the physician must quickly determine whether or not an emergency does, in fact, exist. He must then accordingly reassure the patient of the benign nature of his symptoms or treat the critical underlying abnormality.

Thoracic trauma which causes alteration of the mechanics of ventilation is essentially a surgical problem. We will be concerned here with those conditions in which there is no history of trauma.

Acute Thoracic Pain

Thoracic pain which is sharp and transient and is related to movement of the arms and thorax, with associated local tenderness, may be assumed to originate in the structures of the thoracic wall. Physical examination and roentgenograms of the thorax reveal no abnormality. Treatment with local application of heat and the administration of analgesics suffices.

Sharp pain which occurs with respiration but is not associated with tenderness of the thoracic wall indicates disease of the underlying viscera. If, in the febrile patient, the pain is the result of pneumonitis and pleurisy, the underlying cause should be determined and appropriate antibiotic therapy instituted. If tuberculosis is suspected, early isolation is appropriate.

TABLE 1

Acute Thoracic Pain

Character	Pathophysiologic mechanisms	Etiologic factors
Exertional	Myocardial ischemia	Impaired coronary flow
On inspiration	Pleuritic, musculoskeletal	Pulmonary infarction Pneumonia
On movement of thorax or arms; often continuous	Neuromuscular, skeletal	"Chest-wall pain"
Continuous and oppressive	Myocardial injury Mediastinal shift	Myocardial infarction Spontaneous pneumothorax (tension) Mediastinal emphysema (foreign body) (ruptured esophagus)

Paradoxically, the afebrile patient may present the more ominous emergency. Pulmonary embolization may begin with the early sentinel peripheral pulmonary infarct, to be followed by massive embolization with smothering precordial heaviness. Early bed rest and anticoagulant therapy in the elderly patient with predisposing cardiovascular conditions or in patients having had recent surgery may prevent massive embolization.

Spontaneous pneumothorax may also result in early pleuritic pain or heavy anterior pressure attending a shift of the mediastinal structures; dyspnea usually is also prominent. This emergency situation generally occurs in younger and relatively healthier persons more often than does pulmonary or myocardial infarction, yet it is often confused with these more ominous conditions.

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If the leakage of air into the pleural space is considerable, producing a ball-valve effect, tension pneumothorax develops, and this condition requires immediate action. Insertion of a 16-gauge needle or a trochar will release the tension. The needle should be connected to a tube with the distal end placed under water in a large bottle positioned low at the bedside. Prompt aspiration of a large pneumothorax with a thoracentesis needle and an ordinary suction pump may prevent tension from developing. A flexible metal S-shaped needle may be placed in the second anterior intercostal space and continuous suction applied to maintain re-expansion of the collapsed lung. If this arrangement does not maintain expansion, it may be necessary to insert an indwelling intercostal tube to provide a greater internal diameter and less resistance for continuous suction.

Mediastinal emphysema may complicate pneumothorax. Decompression of the pneumothorax usually corrects this complication. However, one must also suspect aspiration of a foreign body, and therefore bronchoscopy may be indicated. Spontaneous rupture of the esophagus may cause mediastinal emphysema or pneumothorax; this is a rare condition, but it may follow instrumentation or protracted vomiting. Surgical intervention is life-saving.

If cough is a prominent acute symptom, an aspirated foreign body should be suspected; this is especially true in children, but the situation may occur in adults. I recall well the cases involving radiolucent chicken bone and beef bone that had been aspirated by adult men two or three weeks prior to the time the diagnosis was made. The thoracic x-ray films were normal because obstruction was not complete. Atelectasis had not occurred, and there was no ball-valve effect causing obstructive emphysema. The only clue was slightly depressed breath sounds on one side; this led to questioning which revealed that there had been a coughing spell during eating. Dyspnea, rather than thoracic discomfort, was prominent in these patients. This leads us to the second key symptom that may herald a thoracic emergency.

Acute Dyspnea

Dyspnea is an awareness of increased work of breathing. Obstruction of many minor airways or one major airway may necessitate greater effort in ventilation. Stiffening of the lung by congestion or weakness of the respiratory muscles leads to awareness of labored respiration. On the other hand, an anxious person with a perfectly normal bronchopulmonary system may unknowingly hyperventilate and blow off carbon dioxide. He has a feeling that he cannot get a deep enough breath or that the air is not doing him any good. Frequent sighing is characteristic. I use the word "he" in an impersonal sense, for this condition is much more common in women, particularly young, healthy women. There may be numbness of the face and fingertips and, rarely, carpopedal spasm. Reassurance and inhalation of carbon dioxide by the simple method of rebreathing into a bag is all that is necessary.

TABLE 2
Acute Dyspnea

Character	Pathophysiologic mechanisms	Etiologic factors
Tachypnea	Chemical stimulation of central nervous system "Stiffening" of lung	Salicylate intoxication Pulmonary edema Pneumonia
Wheezing	Bronchospasm and bronchial edema	Asthma Bronchitis
Stridor	Laryngospasm or tracheobronchial obstruction	Laryngeal edema Foreign body
Irregular sighing	Psychogenic	Anxiety
Periodic	Depression of central nervous system	Trauma or chemical effect

The character of acute dyspnea is helpful in determining the cause so that it can be quickly corrected. Tachypnea may result from chemical stimulation of the respiratory center as in salicylate poisoning in children. Another chemical, kerosene, causes pulmonary congestion and pneumonia. Gastric lavage is important in such cases if performed early. Oxygen and intravenously administered fluids help support the patient in the acute phase. An endogenous chemical cause of tachypnea is metabolic acidosis related to diabetes mellitus or uremia.

In adults, tachypnea usually suggests stiffening of the lung as in pneumonia or pulmonary edema of congestive cardiac failure. Expiratory wheezing occurs most often in allergic asthma. However, "cardiac asthma" may occur with

pulmonary edema. When the differential diagnosis is not clear, intravenously administered aminophylline in hypertonic glucose solution is a safe medicament to use for either condition until the underlying cause can be clarified.

If cardiac enlargement is demonstrated by physical, roentgenographic, and electrocardiographic examination, Cedilanid® may be given intravenously in two half-digitalizing doses at hourly intervals unless the patient has recently taken digitalis. In patients with allergic asthma, 3 to 6 minims of epinephrine (1:1000 intravenously) may interrupt the attack. If true status asthmaticus is present and conventional drugs are ineffective, massive doses of a corticoid drug may be necessary for a 48-hour period. Intravenously administered hydrocortisone in doses of 100 to 300 mg. over a period of several hours may be life-saving. Several hundred milligrams (or the equivalent of other cortisone analogs) may be administered daily, but the dose should be reduced to maintenance levels in a few days. Only enough should be given to keep the attack under control. Administration of the drug should be discontinued as soon as possible and more conventional methods reinstituted to avoid cortisone dependence.

Respiratory stridor is an inspiratory and expiratory crowing which indicates that a major airway is obstructed. Laryngeal edema is the most common cause in children. Respiratory infection or a foreign body trips off this frightening sequence of events and tracheostomy is often crucial in saving the victim's life. It has been sagely stated that the mere wondering whether tracheostomy should be done is a strong indication for prompt action.

Periodic respiration is usually associated with depression of the respiratory center either by increased intracranial pressure or by depressing drugs. A history obtained from a relative is crucial in attacking the cause, and a neuro-ophthalmologic examination is another important step in this circumstance. Administration of oxygen, often by the use of an intermittent positive-pressure breathing (IPPB) apparatus, is of utmost importance in supporting these patients with decreased ventilation through the emergency period. In patients with increased intracranial pressure, prompt neurosurgical consultation is in order. In barbiturate poisoning, amphetamine, Coramine,® Metrazol,® or picrotoxin should be given intravenously; the dose will be determined by the degree of the patient's consciousness. Inhalation of oxygen is an important adjunct in essentially all the thoracic emergencies of an organic nature already outlined; adequate oxygenation of the tissues, especially the brain, must be maintained.

There is one type of thoracic emergency in which oxygen must be administered with care. Patients with severe emphysema, who have chronically low oxygen and high carbon dioxide tensions in the arterial blood, may have their respiration depressed further by inhaling high concentrations of oxygen. These patients need oxygen badly, but their impaired ventilation must not be further compromised. Assisted ventilation by IPPB or body tank respirators may be necessary to maintain an adequate depth of respiration in these semi-comatose patients. If mechanical respirators are not available, oxygen should be administered by nasal catheter at one or two liters per minute with the amount increased gradually each day so as not to alter abruptly the concentration of oxygen inhaled. Aerosolized bronchodilating agents should be used intensively with the oxygen. Antibiotics should be given to treat any infection, which often precipitates acute respiratory acidosis in these respiratory cripples. When a reversible superimposed infection is the cause of acidosis, the outlook for pulmonary compensation is good.

TABLE 3

Acute Hemoptysis

Character	Pathophysiologic mechanisms	Etiologic factors
Massive	Erosion of artery or vein	Tuberculosis Bronchiectasis
Scant, repeated	Pulmonary congestion Erosion of abnormal tissue	Pulmonary infarction Tumor Broncholithiasis

Acute Hemoptysis

Hemoptysis is frightening to the patient and a cause of real concern to the attending physician. Bronchiectasis and tuberculosis are the most common causes of voluminous hemoptysis. Bed rest and mild sedation are usually advisable until bleeding subsides spontaneously. The

use of drugs to accelerate coagulation is of no help in patients who have normal blood clotting mechanisms. If the eroded vessel in the tracheobronchial tree continues to bleed, thoracotomy for removal of the diseased tissue may be necessary, but this is a rare occurrence. Broncholithiasis and bronchopulmonary tumors may cause hemoptysis, but, except in cases of bronchial adenoma, such bleeding is rarely voluminous.

Conclusion

A variety of thoracic symptoms and signs may cause the patient to seek emergency medical care, but only a few of these require immediate measures of a life-saving nature. The challenge to the attending physician who is the first one to see such a patient is to determine promptly the underlying abnormality and begin specific treatment. In some instances he will need the assistance of a thoracic surgeon. Pulmonary infarction or edema, obstruction of a major airway by a foreign body or by diffuse bronchospasm and edema, tension pneumothorax, ingestion of toxic doses of chemicals, mediastinal emphysema, and acute respiratory acidosis necessitate prompt action.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

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Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville 5, Kentucky.

The General Aspects of Emotional Illness: The Psychiatrist's View* **

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Boston, Mass.

Since a wide variety of symptoms result from emotional conflict arising from disturbed human relationships, the competent physician must be conversant with his patient's psychological as well as his physiological functioning.

A YOUNG woman of 27, married, and the mother of three children under seven, was admitted to the hospital because of the abrupt onset of a feeling she was going to lose consciousness, accompanied by a severe headache and transient difficulty in speaking. These symptoms had occurred while she was waiting for a bus with a friend on her way to work, and their suddenness and severity, as well as her momentary inability to talk sensibly, so frightened her that she persuaded her friend to take her to the hospital emergency ward, where admission was advised for further evaluation.

While she was a patient on the ward, extensive studies (including an electroencephalogram, a pneumoencephalogram and an arteriogram) disclosed no evidence of an intracranial lesion. Although the attending physicians could not be sure that she had not had some brief and poorly-defined abnormality of gross brain function resulting in what was interpreted as a transient aphasia, she was reassured that there was nothing seriously wrong and was discharged.

The patient was somewhat surprised to find that she was apprehensive about leaving the hospital, and when she finally reached home her tension mounted in intensity to near panic. She suffered from repeated episodes of acute anxiety and weakness, was convinced she was going to die of a brain tumor, was often tearful and depressed, and developed such a phobia of the streets that she was completely confined to her house; even there, her symptoms were so severe that she was frequently unable to do her housework, and often spent the greater part of her day in bed. After a few weeks of this miserable existence without relief, she was readmitted to the hospital, this time on the psychiatric service.

During her interviews with her psychiatrist a number of facts were uncovered about her life situation and relationships that appeared highly relevant to the symptoms that had first required her admission to the hospital for neurological studies. In the first place, her job was a source of considerable conflict for her. She had gone to work about a year before when her husband had been incapacitated by a severe back injury, and at his insistence had continued to work even after he had been able to return to his job. She enjoyed her work, a semi-skilled factory position, because of a sense that she was really accomplishing something. At the same time she also felt guilty because of a secret inner pleasure at being stronger and more capable than her husband who was a common laborer. As the months wore on, she found herself growing increasingly tense at work, to a point where she decided to quit. It was then that her husband first angrily insisted that she continue, and the patient despite her mounting discomfort complied, fearing she would lose her husband's affection if she did not please him.

The night before the severe outbreak of symptoms on the street, she was more than ordinarily apprehensive about going to work the next day, and again told her husband she wanted to quit. He exploded in anger, and told

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her that if she did not keep on working, she could "get out of the house." The patient, though both furious and heartbroken at the prospect of losing him and her children, put up no further objections, and quietly cried herself to sleep. The following day it was an effort to control her tension and to overcome a sense of fatigue and weakness, but she managed to start on her way to work—a journey that, as we have seen, ended in the hospital.

In this brief clinical vignette, we find exemplified the major general aspects of emotional problems, and we shall, therefore, proceed to examine and define these with the help of our patient's experiences.

1. Psychological factors contribute to the production of a wide variety of symptoms —mental and somatic.

The microcosm of difficulties suffered by our patient well reflects the macrocosm of psychological symptoms as they are found throughout the realm of human sickness. Let us examine briefly the nature of the relation between psychological factors and illness.

1) There are first of all those symptoms (as demonstrated in the patient's anxiety and depression) which are in themselves exaggerated and painful emotions.

2) Secondly, drives and emotions abnormal in intensity or quality, or abnormally elaborated, may lead to pathological, symptomatic acts such as phobias, compulsions, delinquent behavior or the sexual perversions. The patient's fear of going to work reached the intensity of a phobia, which in itself was partly derived from her fear of excelling her husband. Staying away from work (an action) was a defensive avoidance of a situation which permitted competitive drives to emerge into consciousness that in themselves caused her anxiety.

3) Thirdly, abnormal psychological functioning may be manifested in distortions of mentation such as obsessions, or the severe disturbances characteristic of psychoses such as delusions, hallucinations, and the disorganization of logical thought processes and intellectual functions. Such severe psychological symptoms were not found in our patient, who was suffering from a neurotic illness, rather than a psychosis.

4) And lastly, abnormal psychological functioning may be closely related to bodily disturbances. Here the relationship may be a direct one—that is, the bodily symptoms are a physiological accompaniment of an emotion (the tachycardia and palpitations of anxiety, e.g.), or an expression of a mental concept of dysfunction (the paralyses, sensory disturbances and pains seen in hysteria, e.g.). Symptoms of this sort occurred in our patient in the form of headaches, fatigue, and her feeling of impending loss of consciousness.[1] Or the relationship may be more complex, as for example, in the psychosomatic conditions such as peptic ulcer, ulcerative colitis, asthma and rheumatoid arthritis. In these disorders, the actual physical lesion is the end result of a pathophysiological process, in which psychological disturbances may be one of many important etiological factors producing the end result of bodily disease. Or, finally, psychological factors may secondarily complicate and prolong the symptoms and morbidity of an injury or illness that initially may have had no relation to disturbed psychological function.

2. Symptoms result from psychological conflict.

The problem of the role of psychological factors in the causation of illness is the source of polemic and confusion. Perhaps the safest way to consider the question, doing least injustice to the facts, is to conceive of illness as the reaction of the human organism to environmental stress—a reaction to which both the organism and the environment contribute causal factors. We shall consider certain aspects of the environment in the next section; here, let us focus on the organism.

We assume that the reaction of the organism is at the same time psychological and physiological; in particular we assume that every mental, experiential event is correlated with a chemical and physiological event in the brain. For practical purposes, in investigating illness we study the human being now psychologically, now physiologically, depending on which method provides us with the most useful information. In our present limited knowledge of neurophysiology, for example, we gain a greater understanding of the etiology of anxiety by a psychological rather than a neurophysiological

[1] *The exact nature of the patient's transient difficulty in speaking was never clarified, but suggesting as it did a focal disturbance in brain function, fully justified the extensive neurological evaluation she underwent.*

exploration of the symptom. On the other hand, far more is learned about the nature of heart failure by a study of the pathophysiology of the condition than by a consideration of the conscious experience of the symptoms. Eventually, if our knowledge permits, we may develop concepts that will do away with the dichotomy between the physical and the psychological. Meanwhile we must be prepared and equipped to consider the nature of human illness either physiologically or psychologically.

Just as we consider abnormal physiological reactions to be the result of a patho*physiological* process, so we find that abnormal psychological reactions are the product of processes *psycho*pathological in nature. The essence of psychopathology is psychological conflict. Examples of such inner conflict are seen in our patient: 1) In the first place her wish to work and her pleasure in it came into conflict with her feelings of guilt over surpassing her husband's capacities. 2) In the second place, her wish to quit work came into conflict with her need to keep her husband's affection by continuing at her job.

Each conflict of opposing drives caused her anxiety, and in each case she tried to avoid the painful anxiety: 1) In the first instance, by a move to quit her job (which only faced her with the new dilemma posed by her husband's displeasure), and 2) In the second instance, by developing a variety of symptoms, which led to her hospitalization, and represented a pathological solution of an otherwise insoluble emotional conflict.

3. *Psychological conflict occurs in the setting of human relationships.*

In our consideration of psychological conflict our focus has been on the individual person. But the individual does not exist in a vacuum; on the contrary, he is ineluctably immersed in his environment and the stresses impinging upon him from it. For the majority of human beings, the most important part of their environment is the other human beings in it, and it is from relationships with the people important to them that the stresses leading to inner psychological conflict and symptoms arise.

The loss of an important person by death or rejection or desertion arouses in the affected individual the painful emotions of sadness, anger and insecurity; and the threats of others to withdraw affection, to do physical harm, or in other ways punish, form, by the anxiety they arouse, powerful sanctions against the individual's behavior and show of egotistical drives and emotions. The demands, for example, of our patient's husband and her pressing fear of losing his affection were an essential element in the development of her psychological conflict and the resulting symptoms. The human environment, then, as well as the physical, contains noxious stimuli leading to the formation of symptoms.

4. *The competent physician must be both physiologist and psychologist.*

From our discussion thus far, it has become apparent that the study of symptoms is important only in so far as they lead us to discover the pathological processes resulting in symptom formation—whether these processes are best conceived of as physiological or as psychological. It has also become apparent from our consideration of certain general aspects of psychological factors in illness: (1) The wide variety of symptoms resulting from psychological factors; 2) The essential part that psychological conflict plays in producing symptoms; and 3) The central role of human relationship in causing psychological conflict), that the physician cannot ignore his patients' psychological functioning. He must explore their hopes and fears, their resentments and their sorrows as systematically as he examines their hearts and lungs, their blood and their urine. For an understanding of the nature and cause of our patient's symptoms, for example, and for a rational choice of treatment, it was essential to examine both the neurological and psychological aspects of her total functioning.

In other words, the physician must *listen* to his patients with an ear and mind as educated in human psychological functioning as it is in the physiological. Human emotions and human psychology are not the province of the psychiatrist alone. The latter's particular contribution to medicine, like the surgeon's, is in certain specilized techniques of treatment. Every physician (and especially the internist and general practitioner, who care for the majority of sick people) must understand and be able to examine every aspect of the human organism's reaction to stress. Only then is he competent to diagnose human sickness and to provide rational and intelligent treatment.

The Private Practitioner and His Relationship with Industrial Medicine*

Mac Roy Gasque, M.D.**
New York, N. Y.

Industrial medical programs create a favorable economic impact on private physicians. Acting as a coordinator between supply (physicians) and demand (patients) the industrial physician renders a strategic and valuable referral service to both groups.

INTRAPROFESSIONAL relations is a subject which covers a broad repository of ideas, customs and traditions. A comprehensive discussion of this topic would very nearly parallel a discussion of how we doctors go about the practice of our profession, how we run our business.

In the minds of many medical editors intraprofessional relations seems to be fertile ground, and articles on this subject have been appearing in increasing numbers in medical literature.[1,2] These articles have emphasized the importance of good manners, good mutual patient care, better communications, and similar high-minded and worthwhile principles. All these fine ideas should be supported. We should improve our communications, our manners may sometimes need revitalizing, and certainly mutual patients are entitled to the best possible care. My disinclination to dwell further on these meritorious principles reflects no failure on my part to appreciate their importance. Rather, I feel that these ideas have been well covered and I wish to avoid duplication.

There are other important professional relationships which are economic in nature. Obviously, economic matters cannot be as important as obtaining the best possible care for our mutual patients or as aesthetically appealing as promoting good manners. Nevertheless, they have a certain relevance to all physicians; and since discussions of economic matters so rarely appear in the literature, it is thought, and hoped, that you may be interested in my brief remarks on economy as it applies to our relationships.

It is a well known and accepted fact that a thoughtfully conceived and skillfully rendered industrial medical program can have a favorable impact on such matters as labor turn-over, absenteeism and workmen's compensation insurance premium rates. It is less well known but equally true that such a program can have an important economic effect on the private practice of medicine.

To support this statement, I wish to show you the results of a study of the 10-year experience of a relatively large industry. After 10 years of operation, this industry employed its first full-time medical director. Thereafter, equipment, space and medical staff personnel were acquired. A modern industrial medical program was gradually put into effect.

During the first several months rumblings of suspicious discontent arose from the county medical society. Questions of this sort were asked: "What will you do with all that space and equipment?" "Are you going to take care of employees' families?" "Are you going to treat workers for their personal illnesses?" Slowly and in a climate of mutual good will, the members of the county medical society began to realize that the primarily preventive orientation of the industrial medical program was a viable reality and not just a high-sounding statement of policy gibberish.

Utilization of Blue Cross Insurance

It is extremely difficult—indeed, it is often quite impossible — accurately to place an arithmetical value on the various factors that contribute to the economic structure of medical practice. Nevertheless, an attempt has been

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**Corporate Medical Director of the Olin Mathieson Chemical Corporation.*

made to sort out some of the factors from an industrial medical program as they relate to and bear on the economy of a county medical society.[3] The utilization of a company-sponsored Blue Cross insurance plan by employees is one index of medical economy. To a rather conclusive degree, it can answer the question of whether an industrial medical department absorbs or corrodes the relationship of employees with their private physicians. It can also add light to the question of whether an industrial medical department finds abnormalities and refers employees.

Figure 1 shows the number of claims filed against the company's Blue Cross insurance plan by physicians in the community. During the early years of the study only three members of the county medical society were active in private practice. These physicians are designated as Doctors A, B and C. It should be noted that during the first three years of this study the claims filed by each of these physicians more than doubled. It is thought that a large part of this increase in medical activity was a direct result of the industrial medical program, which, through the medium of employee meetings, medical films and so forth, emphasized the importance of health and publicized the benefit program. Because of the growing medical opportunities, beginning in 1953 three additional physicians migrated into the community. They are represented as Doctors D, E and F.

The total number of claims per year is shown in Figure 2. It is significant that in 1952 the number of claims more than doubled. It was in this year that the services of a second full-time industrial physician were acquired. A program of periodic physical examinations for all employees was begun, and a backlog of abnormalities was uncovered. As a result, literally hundreds of employees were referred to their personal physicians for additional diagnostic study and care.

Although the number of emloyees continued to remain essentially constant, in 1956 another sharp rise in claims occurred. In this year two new services were added to the industrial medical program: An annual gynecologic survey, and a proctologic survey of all men

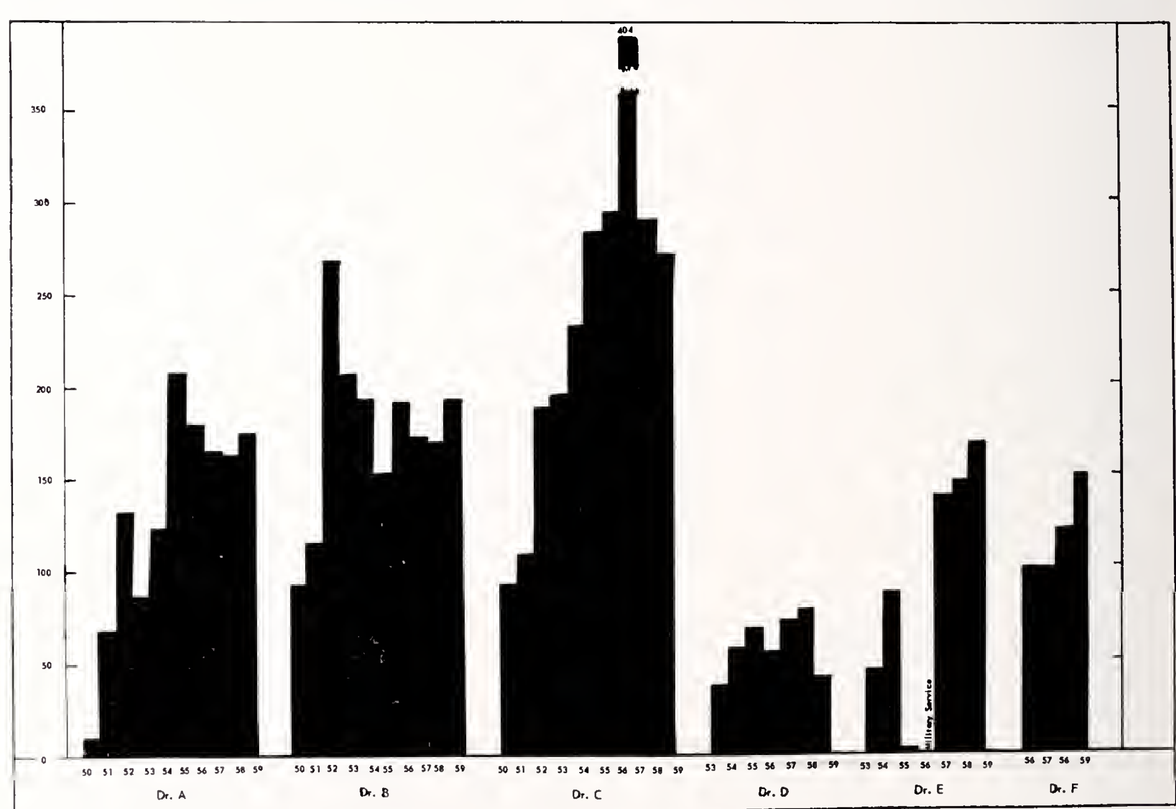

FIG. 1

INDIVIDUAL PHYSICIAN PARTICIPATION IN
COMPANY SPONSORED BLUE CROSS INSURANCE PLAN
YEARS (50 - 59)

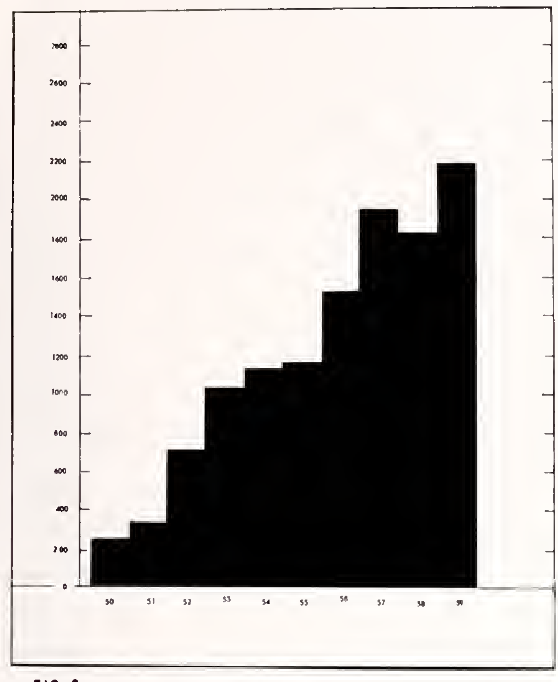

FIG. 2 TOTAL NUMBER OF CLAIMS AGAINST COMPANY SPONSORED BLUE CROSS INSURANCE PLAN YEARS 50 - 59

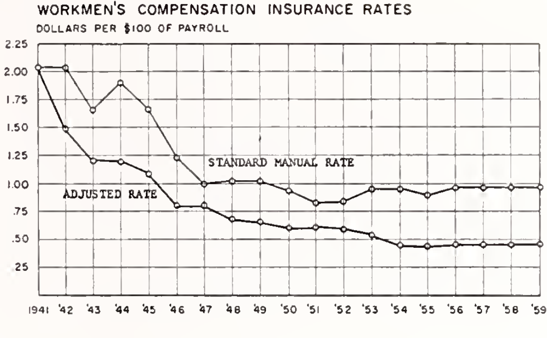

FIG. 3

over 40 years of age. These case-finding services resulted in many additional referrals.

These facts and figures give definition to one type of medical activity which has had a precise and significant impact on the economy of a county medical society. More important is the implication that these figures provide a faithful index of a general increase in community medical interest, resulting primarily from the impetus provided by an active industrial medical program.

It is a fact that many physicians in private practice regard industrial medicine as a somewhat vague, third-party device which may potentially interfere with their private practice. In an effort to dispel the wariness that many feel with regard to the unknown, the following is a description of a program which, with certain modifications, can be adapted to almost any industrial situation.

A Typical Industrial Medical Program

A. Physical Examinations:
1. Preplacement physical examinations
2. Periodic physical examinations
3. Special examinations — toxic exposure
4. Back-to-work examinations after illness

B. Therapeutic Services for:
1. Industrially induced illnesses and accidents
2. Personal illnesses and accidents (limited)

C. Health Education

D. Industrial Hygiene

E. Medical Records

F. Special Activities:
1. Preventive immunizations
2. Follow-up for chronic diseases
3. Clinical psychology service
4. Foot care service
5. Proctology survey
6. Gynecology survey
7. Diabetes detection service
8. Miscellaneous

Industry pays the bill for all this, and industry should be able to demonstrate value received. Values for medical services aren't easy to define in arithmetical terms. Yet there are certain indications, such as the decrease in workmen's compensation rates paid by the company described earlier, as shown in Figure 3. In this same industry labor turn-over was studied. Experience in this field is shown in Figure 4. Many other economic benefits accrue

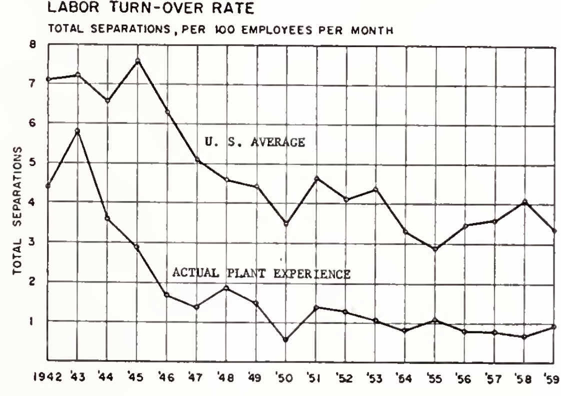

FIG. 4

from a thoughtfully rendered industrial medical program.[4, 5] These benefits have been insufficiently documented in the literature.

The Industrial Physician as a Medical Coordinator

There is another emerging economic professional relationship which is seldom recognized, poorly understood, and only occasionally discussed. In this relationship an industrial physician can properly be called a coordinator of medical services.

To illustrate: The traditions and customs of private medical practice do not allow physicians to solicit patients. The man who reads your electric meter may have a goiter as big as a baseball. The man who fills your gasoline tank may weigh 240 pounds. Even though they obviously need medical care, good taste, good ethics do not allow the physician in private practice to make overtures to them. But in industrial medicine the ground rules are different. Good taste, good ethics, even good business require that the industrial physician call in employees with known or suspected abnormalities. Acting as a coordinator of medical services, the industrial physician examines, counsels and refers employees to private physicians for definitive care. The more energetic and thorough this job, the more cases are found, the more are employees referred. Presumably this has favorable economic implications.

In coordinating the demand for services with the supply of physicians, nothing new is being created. Instead there is being achieved a fuller utilization of already existing talents and facilities. Probably no other medical specialist is in such a favorable posture to accomplish this coordination.

Industrial medical offices have budgets, which, for all practical purposes, are controlled by industrial physicians. Funds can be used for all manner of things—salaries, equipment, supplies. In addition, they can be used to call in clinical consultants. These consultants can function in many ways to carry out and fully develop the special activities described earlier in the program. For example, women in industry often are gynecologically neglected. Industrial gynecologic surveys have provided an important protective service for female employees.[6] The industrial physician, using his budget to bring in consultants to run these clinics, is again acting as a coordinator of medical services. Proctoscopy and diabetes detection are other obvious areas in which consultants can be used and coordination of medical demand/physician supply can be achieved.

The potential intraprofessional value of more deliberate and extensive utilization of the industrial physician as a medical coordinator justifies further recognition and development.

Summary

Modern industrial medical programs are designed to audit the health resources and vocational expectancy of workers. Orientation is toward health promotion by means of education and case finding with subsequent referral for study or therapy to conventional sources—ordinarily the private physician.

An attempt has been made to illustrate and emphasize the importance of two economic relationships that can and should exist between private physicians and industrial physicians. These are:

1. A thoughtfully conceived, skillfully rendered industrial medical program creates a favorable economic impact on community medical affairs. The over-all program operates to stimulate interest in health among workers, their families and the proximate population.

2. The aware and alert industrial physician can provide a service of tremendous value to the profession and to his industry when he acts as a coordinator of supply and demand—the supply being the available reservoir of medical talent and the demand coming from the need for disease eradication (or, more positively stated, the need for health promotion) among industrial workers and their families.

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The Structure of the U. S. Public Health Service and Its Relationship to State and Local Health Departments*

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Louisville, Ky.

Assistance to and support of state and local health efforts is a major function of the Public Health Service. Why and how this support function operates is discussed.

THE structure and relationships of the U.S. Public Health Service are based on, and determined by, federal laws enacted by the Congress of the United States. I believe quite sincerely that the Congress enacts those laws that represent the wishes of the majority of the citizens. Thus, we could say that the structure and relationships of the Service are what the American people want them to be—within the framework of the Constitution.

What laws then has the Congress enacted relating to what the Service shall do about the health of the public in general; about how the Service will be organized, and what it shall do for, with, through, or in spite of, state and local health departments? Actually only two short sections of the Public Health Service Act cover the entire field and all other authorities granted to the Public Health Service are granted within the framework of these Sections. These sections are:

Section 301. "The Surgeon General shall conduct in the Service, and encourage, cooperate with, and render assistance to other appropriate public authorities, scientific institutions, and scientists in the conduct of, . . . research, investigations, experiments, demonstrations, and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and impairments of man. . . . "

Section 311. "The Surgeon General shall also assist states and their political subdivisions in the prevention and suppression of communicable diseases, shall cooperate with and aid state and local authorities in the enforcement of their quarantine and other health regulations . . . and shall advise the several states on matters relating to the preservation and improvement of the public health."

Please note that the words regulate, control, direct, determine, supercede, overrule, dominate and similar authoritative verbs are omitted from the basic federal law. This is done not only as the intent of the Congress but also it is in accordance with the desire of the Service. The officers of the Public Health Service have always believed in states' rights and have no desire to assume any functions except those the Service carries out for the states, and with their full concurrence and cooperation.

Philosophy and Results

Mustard[1] has described very well, in one paragraph, the general philosophy of the Public Health Service, its actions within that philosophy, and the results it has obtained in working with state and local health departments during the 164 years of its history:

"DEVELOPMENT OF STATES' RELATIONS—The United States Public Health Service occupies an enviable and commendable position in its relationships with the health authorities of the several states. Through grants-in-aid, through loan of personnel, through consultation and careful observation of protocol, this Service is perhaps, of all federal agencies in any field, the one which exhibits the practicability of coordinated action between a federal union as a whole and its in-

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dividual constituent members. Indirectly and intangibly, too, through high standards of performance and through demonstration and efficiency, the Public Health Service has raised the level of work performed in every county, city, and state health department with which it has had even indirect contact."

What then does all this mean in everyday work in State and local health departments in Kentucky? How can, and will, the Public Health Service "encourage, cooperate with, render assistance to, advise and aid" you with your problems and your programs in Frankfort, Pikeville, Lexington, Short Creek, Louisville, Leon, etc.? What is available to each of you? How do you go about getting it? How do you proceed to secure the funds, the consultation and the personnel available?

I would serve no useful purpose by showing you an organization chart of the Public Health Service. We have no concern here, I believe, with the numbers and names of the various administrative units of the Service. It matters not, to you or to me, whether a particular consultant works at, or derives a fund from, the Bureau, division, branch, program, or office level. We are concerned with the area and extent of the consultant's particular competency and how we secure the funds or services needed for use in the solution of local or state health problems.

I shall not dwell at length on funds although I should say they are rather adequate. The appropriations of this year, by purpose, are:

	(In Thousands)
COMMUNICABLE DISEASE ACTIVITIES	$ 10,062
TUBERCULOSIS	
Grants to States	3,250
Special Project Grants	1,250
VENEREAL DISEASE	4,585
DENTAL RESOURCES AND SERVICES	3,006
HOSPITAL CONSTRUCTION	226,220
Part C	150,000
Part G	70,000
Nursing Homes	20,000
MILK, FOOD, INTERSTATE AND COMMUNITY SANITATION	8,536
WATER SUPPLY AND POLLUTION	24,707
NIH	
General Research and Services	159,826
Cancer	155,742
Mental	143,599
Heart	147,398
Dental	21,199
Arthritis	103,388
Allergy	66,142
Neurology	83,506

You know that federal funds are available to and are being used in Kentucky for support of basic health services, for research and field investigation, for demonstrations, and for the development of new and improved methods of preventing disease and premature death. It is quite likely such funds will continue to be available—with the possible or even probable exception of general support funds. These may disappear within a few years. There is no reason to even suspect that federal research, investigation, demonstration and promotional funds will be decreased.

Consultations

A well-developed mechanism exists also for supplying, to any state or local health department, consultation on any aspect of any disease, condition, health problem or health program. I realize that this is a very strong statement but I stick to it. If the consultation is not available from the regional office, headquarters, or one of the Centers of the Service, arrangements can be made for the assistance from another state health department, from a university, or from any place where the exceptional ability exists. There are, however, a few rules about this consultation service that should be firmly in the mind of anyone seeking such help.

First the consultation must be requested, needed and wanted. I think of consultation as something like training a bird dog. In order to be effective as a bird-dog trainer, it is first necessary that you know something about hunting that the dog does not know. Secondly, the dog must recognize that you have exceptional knowledge or ability in hunting and, lastly, the dog must want to improve his performance by his association with you. If any one of these factors is missing, no training will result. Similarly, the inept and incompetent consultant is absurd. He has nothing to impart. The unwanted consultant is both futile and a nuisance for obvious reasons. It is wasteful finally to consult with an individual who has no desire to improve himself.

A factor often misunderstood in the consultant-consultee relationship is that the consultant should always be requested through established administrative channels. This means that local health departments request help from the state, state health departments request help from the Service, and these requests, without exception, should be directed to the regional of-

fice of the Service. In your case this is the Regional Office in Charlottesville, Va. I cannot emphasize this point too vigorously. Nothing can be more wasteful of public funds or more frustrating to all persons concerned including both the consultant and consultee than the local health department or official who insists on dealing directly with an immature "consultant" of the Service who accedes, temporarily, to reciprocal short-circuit relationships. I have had to spend many hours straightening out the misunderstandings resulting from these free-wheeling arrangements.

At least 90% of the help needed in local health departments can be supplied by the state health department. The remainder will be requested from a university, the Public Health Service or some other source of such help. Also interpretation of the request and evaluation of the need is required at every administrative level. The state health departments are admirably suited to carry out these functions. Regional offices of the Public Health Service were established originally to perform this role of interpretation and evaluation and it will remain as one of their principal services to the Surgeon General and to the state health departments whom they serve.

I have discussed in very general terms, the principal functions of the Public Health Service as they relate to states and the type of help or aid available from the Public Health Service. I have outlined how you go about applying for it. I have not, as yet, covered any aspect of what initiates the flow of funds, the assignment of personnel, and the support and advice of the most learned consultants available. The triggering mechanism, the focus toward which attention, personnel and funds are directed, is the idea you have developed, the new program you have conceived, the investigation you have planned.

Local Accomplishments

Kentucky has a magnificent history of accomplishment in the field of public health. Kentucky public health workers have developed many new ideas, have conceived new methods of health service and have contributed much to public health knowledge through research and investigation. It has been pleasant, stimulating and gratifying for the Public Health Service to be associated with Kentuckians in these undertakings. Some of the recent Kentucky public health developments receiving national attention are your public medical care program, the assumption by Kentucky of State responsibility for radiological health protection of its citizens and the compulsory vaccination program enacted recently. I have every confidence that Kentucky and its responsible health officers will continue to stand in the forefront of progress in the preservation of human health.

In the Department of Community Health of the University of Louisville School of Medicine we are making every effort to help the student prepare for effective participation in: (1) Comprehensive health care of individuals and (2) The solution of health problems of communities. Through enlightened cooperation of the private practitioners of medicine with public health physicians the major problems of the public's health can be solved. This has been your distinguished record of the past and every sign points to an even more illustrious future.

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Observe —

Immunization Week

May 5-11

EDITORIALS

Motivation and Freedom in Medicine*

I WANT TO preface my remarks with an apology to those of you who feel that a non-scientific presentation is "out of line" and may continue a precedent in the wrong direction. I make no apologies for the content of this paper, however, and do hope that you will find this worth your time and attention.

I am not so presumptuous as to think that I can sit in the position of perception and judgment of a patriarch. Naturally, my remarks will have to be taken with the same weight as the amount of these powers that I possess. I speak from 42 years' experience in living, 19 years' experience as a doctor of medicine and 13 years' experience as a private practitioner of medicine. My entire contact with organized medicine has been through this Society.

From this background I want to present to you some observations and conclusions which have been mine. There are many facets in the practice of medicine and in organized medicine which concern me, but there are two considerations that I especially would like to deal with. They are motivation and freedom.

Nationally the attention of the medical profession has been attracted to its public image and one might deal with that aspect. To the image problem, I say, "Forget it." The image per se should not concern us as practicing doctors. The question we should ask ourselves is, "Am I attending to my assumed duty properly?" An appropriate corollary might be that of a parent who is continually involved with his image. He cannot properly rear his children because there are many duties which, if properly attended to, will affect his image adversely but will serve the best long range interest of his child. He should ask himself the same question over and over again, "Am I right?" Our course should be the same.

*M. Randolph Gilliam, M.D., Lexington, president of the Fayette County Medical Society, delivered this paper as his presidential address before the Society February 12, 1963.

We are in an era where service and charity and where subjugation of one's interest in favor of another are considered by many to be naive, or at least unsophisticated. There is too much of the "Madison Avenue" approach where service is calculated, and the right hand must always know what the left hand is doing. The concept of work as a center point in life is receiving less emphasis, with more emphasis being placed on shorter working hours and security arrangements. There is a progressive trend to invert the work-recreation ratio so that more and more people are thinking in terms of working in order to recreate, rather than recreating in order to work.

Man in our time has developed an inflated faith in organizational or group solutions to his many problems. He exhibits a bent for ignoring the foundation and supporting superstructure and becoming involved with the superficial appointments and decor. We of the medical profession are no exception. I state here without reservations that the solutions to our problems will be forthcoming when the rank and file practitioner of medicine is properly motivated. What is this motivation? It is the motivation to service in its highest connotation. The question may be asked, "Aren't all physicians involved with service?" My answer is, "If we were all primarily involved with service, our image wouldn't be a problem"—and it is a problem.

Our approach should not be that of a chameleon, but rather we should establish and maintain our proper color and by influence of example our color may tint our order to the advantage of all. To the person who finds it difficult to swim against some of the strong currents of our time Henry Van dyke gave these words of encouragement in writing "The School of Life."

"Individuality is the salt of common life. You may have to live in a crowd, but you do not have to live like it, nor subsist on its food."

The medical profession's franchise in our society was won by the devotion of a sizable proportion of our predecessors in attending to their patient's needs. This devotion to which I refer is a very positive thing which knows no barrier and is not satisfied by the mere attendance of a patient during his illness. Such devoted men are truly concerned about the people they care for and therefore attempt to know and communicate with them. The warm heart which motivates this type of service will enter areas into which the intellect by itself cannot travel. It can, however, take the knowledge and tools of the intellect with it and for this reason is a common denominator of all great physicians. The physician who distorts his service to people in order to fulfill personal consideration of any nature distorts the total picture image of the profession to just that extent.

What is the difference between this higher type of service and the type which is too much with us? The key to the difference is that in the former type the physician is primarily involved with the patient and in the latter he is primarily involved with himself. The latter man will place many conditions on his services which reflect his ego, pride and prejudices. He will not be cognizant of many of his patient's problems and needs because he has erected barriers which will impede true communication with him. He will tend to be fractious when his patient questions him in areas that involve his skill and management. He will be impatient with the patient's fears of and resistance to proposed treatment. He will tend to deal with the patient's family's concern in a manner that will not answer their needs.

If we are primarily interested in the monetary compensation in medicine, our profession will become a business, in which case we should not be surprised if our patients begin to look upon us as businessmen and we them as customers. Our rewards will be, as in the business world, measured in monetary terms.

If we participate in medicine primarily as an intellectual exercise and challenge we should not be surprised if our patients begin to see us as unreachable eggheads, because our interest in our patients' problems will be in proportion to what we judge to be the magnitude of the challenge presented.

We all know that many times what a patient considers to be a major problem may present no intellectual challenge or stimulus. Nonetheless what is important to the patient is important enough to deal with, and deal with, with sufficient enthusiasm, to bring about a solution for him. Only devotion to service can carry this load.

How do we get this direction and motivation for our profession? We get it by adding fuel to the fires now burning, thereby enabling them to spread. Our profession as it now exists will be the better for it and the picture painted will attract younger men and women to our profession, who are so motivated. The motivation of which I speak cannot be assimilated from intellectual pursuit. It will spread by example and by contact with spirits of men of such structure.

James Russell Lowell has authored one of my favorite statements which restates this belief in magnificent prose—"Be Noble! and the nobleness that lies in other men, sleeping but never dead, will rise in majesty to meet thine own."

I do not minimize the pursuit of technical and intellectual excellence as a necessary adjunct. Such a statement is probably redundant, but I make it to clarify my position. Given the same set of tools of skill, however, unquestionably the noble physician will outstrip his basically materialistically or intellectualistically motivated colleague in effectiveness to an extent that will be incalculable.

We have, individually and as a group, been concerned with the socialists in our society who would control us and as individuals defeat us. We have presented many and varied arguments to offset their proposals, both didactic and legislative. In the main we have let them call the shots, so to speak, and we have been put on the defensive. The best weapon we could have is a collective group of individuals who are dedicated to selfless service. If we wage war with the socialists on an economic basis, we fight them with their own special weapons and we will lose. The sterile socialist does not really understand the man of whom I speak, who is a power of high magnitude and whose creative goodness cannot be measured in economic terms. If we wage war with the socialist with men of this mold we cannot lose because our weapons will be far superior and we will be indestructible.

Our profession, then, seeks a continuation of its freedom. What, I ask you, is this freedom

we cherish so much and which is in jeopardy? This possible loss of freedom is a threat not alone to our profession but to all men. These movements within the framework of our country, the major stronghold of individual freedom, would enslave the individual to a materialistic tyranny. They would control all of its subjects on the theory that as individuals they are not capable, either by nature or desire, or both, to fulfill their responsibilities.

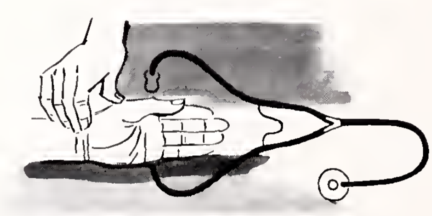
If one holds to the idea that man was created by God to be a free agent to pursue his talents and responsibilities with inner direction, then that person has to place on the individual unavoidable responsibility for his course. Where his course is elsewhere directed he obviously has no responsibility for this direction. That seems simple enough.

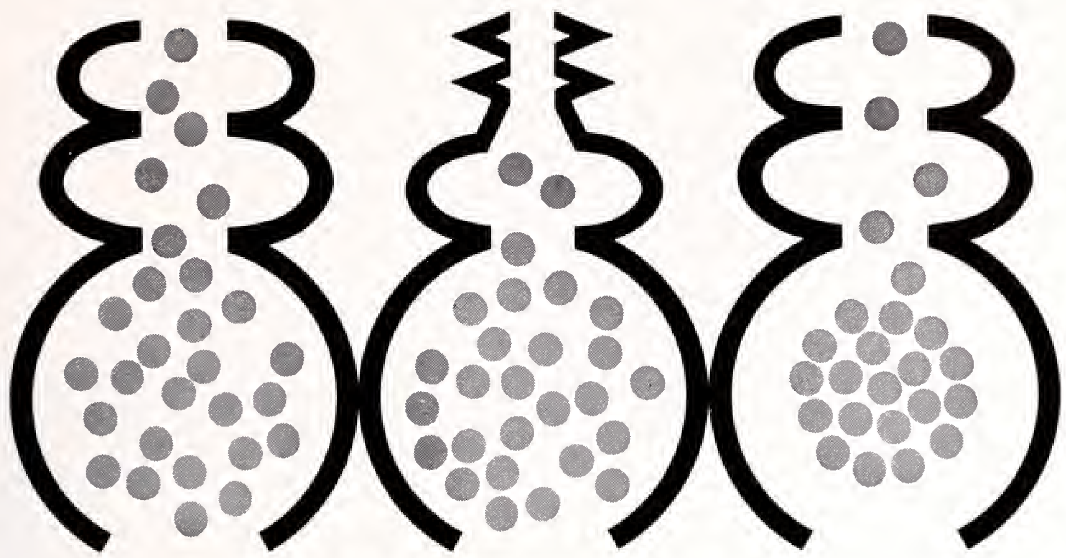
The individual, however, having accepted the responsibility for mapping his course has freedom only to do a responsible job. Has he freedom for the primary pursuit of self just because he is not externally controlled? A cell cannot pursue its own interest at the expense of its contribution to the body without adversely affecting the body economy. This would be malignant growth. In such a process the body is not only destroyed but the culprit also. The cell serves itself best when it serves the body responsibly. The individual, as the lesser entity, serves himself best, by the same token, when he serves the greater entity responsibly. This cannot be done by external direction because the motivation for this is from within, if it exists at all. Service of a superior quality requires freedom for its existence. Freedom to serve requires devotion to service for its existence. Freedom and service are interdependent in the realm of true professions.

Therefore: The inalterable and continuous price of freedom for us is self-discipline. Freedom may be inherited from a previous generation but each individual in his time must pay the price or forfeit the prize.

Devotion to service is the discipline and, therefore, the price and freedom is the prize—and there is a bonus—our public image will be more than acceptable.

M. Randolph Gilliam, M.D.





lowers motility | relieves cramping | stops diarrhea

LOMOTIL® Antidiarrheal tablets and liquid

(brand of diphenoxylate hydrochloride with atropine sulfate)

Traditionally the most effective means of slowing excess intestinal motility in diarrhea and so of relieving the disorder have been the opium derivatives. Now Lomotil makes available an antidiarrheal agent[1] of greater therapeutic efficiency than morphine.

By controlling hypermotility, the basic mechanical dysfunction of diarrhea, Lomotil reduces the frequency and fluidity of stools, diminishes cramping and controls diarrhea in many patients in whom other drugs have proved inadequate.

In a recent clinical report Cayer and Sohmer[2] state: "The alleviation of symptoms [with Lomotil] was usually prompt, occurring within 24 to 72 hours even in the long-standing chronic cases. . . . A surprisingly satisfactory response was obtained in 75 per cent of the patients with regional enteritis and in 63 per cent of those with ulcerative colitis, all of whom had failed to respond to other measures."

The high therapeutic efficiency of Lomotil, its safety, convenience and economy may be used to advantage in acute or chronic diarrhea.

Dosage: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily. Maintenance dosage may be as low as two tablets daily.

Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

Note: Lomotil is an exempt preparation under Federal narcotic statutes.

Detailed information and directions for use in children and adults are available in Physicians' Product Brochure No. 81. G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholino-Butyrylpyrrolidine and Related Amides. I. Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. 9:381-400 (June) 1957.
2. Cayer, D., and Sohmer, M. F.: Long-Term Clinical Studies with a New Constipating Drug, Diphenoxylate Hydrochloride, N. Carolina Med. J. 22:600-604 (Dec.) 1961.

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why let antihistamine drowsiness leave the job half-done?

It makes good sense to start your *active* allergy patients on Dimetane Extentabs. The response of a Dimetane-treated patient is eloquent proof that a *potent* antihistamine doesn't have to be a sedative, too. Most types of allergies respond quickly — most patients become symptom-free *and* stay on the job for Dimetane works with a very low incidence of significant side effects. Indeed, as one double-blind crossover study revealed, *with no greater incidence of sedation than placebo.** Also available as conventional tablets, 4 mg.; Elixir, 2 mg./5 cc.; Injectable, 10 mg./cc. or 100 mg./cc.
*Schiller, I. W. and Lowell, F. C.: New England J. Med. 261:478, 1959. A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

CONTINUOUS ACTION UP TO 10-12 HOURS

Dimetane® Extentabs®

(brompheniramine maleate, 12 mg.)

UNSURPASSED RELIEF OF ALLERGY SYMPTOMS
...WITH NO MORE SEDATION THAN PLACEBO*

in duodenal ulcer therapy

To dramatize the healing of peptic ulcer, our photographer burned a "lesion" into crumpled metal with a blowtorch, then repaired it and photographed the result.

solid results!

This is the kind of response you can expect with Robinul therapy.

Because Robinul's anticholinergic action is so specific, so intense, and so consistent, it provides a favorable internal environment for ulcer healing.

Positive suppression of gastric acid volume. Moeller[1] demonstrated that 2 mg. of Robinul decreases the volume of HCl secreted by 73% within one hour and 85% within two. Epstein[2] described Robinul's "intensive antisecretory action" as "exemplary."

Significant increase in gastric pH. In his studies comparing the effect of anticholinergics on gastric pH, Sun[3] found that the optimum effective dose of Robinul "...produced suppression of gastric acidity to pH 4.5 or higher in all 16 patients examined." Posey[4] reported "an excellent reduction of gastric acidity...in 12 of 15 patients...."

Desirable antimotility effect. Young and Sun[5] found that although Robinul (given subcutaneously) demonstrated its ability to suppress antral motility, a 2 mg. oral dose "did not affect gastric emptying or intestinal transit time" in six patients with duodenal ulcer.

New freedom from side effects. Robinul has shown that an anticholinergic need not be plagued with a high percentage of side effects. Of 1705 patients in clinical investigations, many of whom were studied on above-normal doses, fewer than 7% experienced side effects of a moderate-to-severe degree, with only 3% requesting discontinuance of the medication.

PRESCRIBING INFORMATION:
Robinul and Robinul-PH have provided good to excellent results in 83.1% of 795 reported cases of peptic ulcer.

SIDE EFFECTS: Dryness of mouth, blurred vision, urinary difficulties, and constipation are seldom troublesome and may generally be controlled by reduction of dosage. Other unwanted effects such as rash have been reported, but only very rarely.

PRECAUTIONS: Administer with care to patients with incipient glaucoma. Contraindicated in acute glaucoma, prostatic hypertrophy, and in presence of urinary bladder neck obstruction or pyloric obstruction or stenosis with significant gastric retention. Robinul-PH is contraindicated in patients sensitive to phenobarbital or with advanced hepatic or renal disease.

REFERENCES: 1. Moeller, H.C.: Ann. New York Acad. Sc. 99:158, Feb. 28, 1962. 2. Epstein, J. H.: Am. J. Gastroent. 37:295, 1962. 3. Sun, D.C.H.: Ann. New York Acad. Sc. 99:153, Feb. 28, 1962. 4. Posey, E.L., Jr.: Am. J. Digest. Dis. 7:863, 1962. 5. Young, R., and Sun, D.C.H.: Ann. New York Acad. Sc. 99:174, Feb. 28, 1962.

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PHARMACEUTICALS RESEARCH

Robinul®

ANTICHOLINERGIC

Brand of glycopyrrolate,* 1 mg. per tablet

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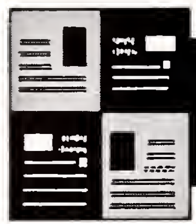
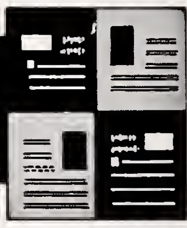
ANTICHOLINERGIC/SEDATIVE

Glycopyrrolate, 1 mg., and phenobarbital, ¼ gr. per tablet

*U. S. PATENT NUMBER 2,956,062



SPECIAL ARTICLES



Letter to a Statesman

(Anonymous)

To the Editor
The Kentucky State Medical Association Journal
3532 Janet Avenue
Louisville 5, Kentucky

Dear Sir:

This preliminary draft of a letter was found discarded in a local campaign headquarters after the 1962 fall senatorial election. As it is undated, with the addressee and signature omitted, we have no clue as to the identity of our bucolic Ben Franklin.

The course of the campaign suggests that either the letter was not transmitted or that it was ignored. My guess is that our unknown friend realized that no polishing of phraseology could make these homilies acceptable to his Patron.

Sincerely,
George F. Brockman, M.D.

E*xcellency,*

It will not have escaped your observation that our physicians, in large measure, have ventured into elective politics; and that they have even attained a measure of success. This is a new consideration of Gov't, especially as doctors, from the nature of their practices, tend to be independent in action, little given to joint actions, even with each other. The seven doctors who signed the Declaration of Independence had at least as many colleagues who removed to Canada, rather than live in our new Republick. Because of the novelty of this venture by the Drs, I give you my reflections upon it.

It seems our tradition from England that the doctor should partake of the affairs of government as a citizen at the polling places; but I find no record that there was ever any thought of their banding together to influence the General affairs of State. As the doctor's studies and observations showed where Gov't might act to lessen the ravages of Disease, the leaders of the State gave ear to the medical recommendations, and applied them for the general welfare. I might remind you of Quarantine regulations, the improvement of the publick water supplies for the abatement of Typhoid and other Fevers, laws for vaccination against Smallpox; and even on to the present time, with the new law for the protective inoculation of all school children and the Sabin Sundays to Vaccinate Against the Infantile Paralysis. I need not dwell on the benefits to the publick welfare which have followed from these wise measures.

Three decades ago, I have been reminded, this fruitful relationship was set aside by the Chief of the State, who you will readily recall as of the same political persuasion as your Excellency. He excluded the physicians from his Councils, giving ear to a group of advisers who were seeking to introduce into our Republick the old European thought that

the State should manage the affairs of every citizen (for his own benefit, as they hold that the planners of the State have greater wisdom in planning for his Happiness than has any citizen in planning for him Self). His Excellency proposed that the doctors should be employed by the State, that the State might give medical care to all.

The great body of the doctors would have nought of this. The Congress, hearing from the people as well as the doctors, did not adopt this plan. This angered his Excellency, who flayed the doctors, classifying them as Bourbons among the Princes of Privilege. The leaders of the Democratic party have adhered to this platform since, barring the doctors from their councils.

I have discus't this with many of the doctors. Most of them, I find, were raised on the principals of Thos. Jefferson. They feel harrassed, that our Party has cast them forth, in advocating Philosophies alien to those of Jefferson. Being studious by nature and training, and seeking to defend their belief and practices, many of the doctors are progressing rapidly in a study of the methods (including those of your Excellency) for influencing the Electorate. However, to a man, they still express an abhorrance of politics (save only in their own Societies).

I venture to address these lines to you with the hope that it may seem that the care of the sick is a matter for the physicians; that to again admit the doctors to the Councils of Gov't would free your Excellency for the larger problems of State with which we are sorely beset.

Admiration of your Excellency makes me fear for your profile in history when I hear the thin veil of veniality in our plea, almost as: "Take thou, therefore, no thought for thy father or thy mother; the State will take heed for them." Also, I confess that, should I be struck by infirmity, I would rather my physician give full attention to me, than that he needs must keep an eye peeled to observe what next his Gov't might have in mind to do to him.

Your obedient servant,

Make Your Plans Now

To Attend

The AMA Annual Meeting

in

Atlantic City

June 16-20

ORGANIZATION SECTION

Meetings Scheduled by Three KSMA Trustee Districts

The Second, Fifth and 10th Trustee Districts of the Kentucky State Medical Association have scheduled meetings for April and May.

The Second District, for which Howell J. Davis, M.D., Owensboro, is trustee, will hold a meeting April 11 at Owensboro. Speakers will be David M. Cox, M.D., Louisville, KSMA President, and Hoyt D. Gardner, M.D., Louisville, chairman of KEMPAC. Doctor Cox will speak on "You, the KSMA and the Patient," and Doctor Gardner on, "Vote Now or Pay Later."

Louisville Mayor William O. Cowger and K. P. Vinsel, executive secretary of the Louisville Chamber of Commerce, will address the meeting of the Fifth Trustee District at Louisville, April 15. Trustee is Carlisle Morse, M.D., Louisville. The Mayor will have as his topic, "Importance of KEMPAC and the Political Action of Doctors," and Mr. Vinsel, "Economic and Political Horizons—1970."

The 10th Trustee District will hold its meeting May 14 at a time and place yet to be announced. Douglas E. Scott, M.D., Lexington, is 10th District trustee.

The 11th Trustee District meeting March 14 at Richmond was attended by 40 physicians. Hubert C. Jones, M.D., Berea, is trustee. The meeting was addressed by Doctors Cox and Gardner.

The 12th and 15th Districts held a joint meeting at Cumberland Falls State Park March 28. Doctor Cox and Doctor Gardner addressed the meeting. Thomas O. Meredith, M.D., Harrodsburg, is trustee for the 12th District and Keith P. Smith, M.D., Corbin, for the 15th District. On the same day, the 14th District, for which William C. Hambley, M.D., Pikeville, is trustee, met at Jenny Wiley State Park. Addressing the meeting were Henry B. Asman, M.D., and Robert W. Likins, M.D., both of Louisville.

KSMA Nominating, Awards Groups Seek Recommendations

Following meetings of the Nominating and Awards Committees of the Kentucky State Medical Association during the KSMA Interim Meeting at Covington, March 7, both groups are urging members to submit recommendations for officer candidates and for awards recognition.

Loman Trover, M.D., Madisonville, elected chairman of the 1963 Nominating Committee at the Covington meeting, reports that his committee has received recommendations for the office of president-elect who this year will be from Western Kentucky, as provided in the bylaws. Doctor Trover stated that the committee would like to receive suggestions for nominations for the other officers. In 1963, he said, a secretary and a treasurer of the KSMA will be elected to serve three-year terms.

The Awards Committee, headed by W. H. Bizot, M.D., Louisville, after a meeting at Covington, has made plans for a member of the committee to contact each county society and seek nominations for the awards which will be made at the Annual Meeting, September 23-26, at Lexington. County society members, Doctor Bizot said, should be ready to make suggestions as to nominees to receive the awards which are: Distinguished Service Award, Outstanding General Practitioner Award and the R. Haynes Barr Award.

Medical Films; Color TV Planned For AMA Annual Meeting

More than 40 medical films and a program of closed color telecasts are to be shown and featured at the annual meeting of the American Medical Association June 16-20 at Atlantic City. The telecasts will originate in the University of Pennsylvania Hospital at Philadelphia.

The films will cover, among many subjects, blood transfusions, abdominal injury, thoracic injuries, management of burns, tetanus, diagnosis of strokes, gastroscopy, kidney transplant and gastric cooling.

Featured presentations at the 40th annual convention of the Woman's Auxiliary to the AMA will advise how physicians' wives can best serve their local communities and how they can tell the public and the profession about service projects. Such service activities are in the areas of civil defense, health career recruitment, mental health, international health, safety and rural health.

National Auxiliary past presidents will be honored at a luncheon with George M. Fister, M.D., AMA president, as guest speaker. The president and the president elect—Mrs. William Thuss of Birmingham, Ala., and Mrs. C. Rodney Stoltz, Watertown, S.D.—will be honored at the annual tea.

Hospital Week May 12-18

National Hospital Week will be May 12-18, according to an announcement by Edwin L. Crosby, M.D., director of the American Hospital Association. Theme of 1963 Hospital Week will be "Today's Hospital—Career Center for America's Youth."

Ky. Poison Control Conference Scheduled for May 22-23

The Second Kentucky Conference on Poisons and Poison Control and the First Kentucky Conference on Environmental Toxicology and Occupational Hygiene will be held May 22-23 at the Kentucky Hotel, Louisville. The first is sponsored by the Executive Committee of the Kentucky Poison Control Program in cooperation with the Kentucky State Department of Health and the second is co-sponsored by the Committee and the University of Kentucky Institute of Environmental Toxicology and Occupational Hygiene.

On May 22 there will be a dinner meeting with a speaker to be announced.

Problems of agricultural, industrial and environmental toxicology will be considered at the session May 22, along with occupational hygiene and safety practices; the training of occupational health specialists; health control; occupational diseases, and others.

On May 23 subjects to be considered will include: Antidotes for acute poisonings; adequacy in labelling; laboratory analysis; public education; clinical poisonings; legal responsibility in emergency poisonings; practical management of acute poisonings.

For further information and registration applications write: Victor B. Fuqua, secretary, Kentucky Poison Control Program, State Department of Health, Frankfort. Registration fee is $5 which covers the dinner and either or both meetings.

The Kentucky State Medical Association along with other health and rural groups is a member of the Poison Control Program.

Ky. Thoracic Society Plans Full Program for April 25

The tentative program for the annual meeting of the Kentucky Thoracic Society April 25 at the University of Kentucky Hospital Auditorium, Lexington, has been announced by Jerome E. Cohn, M.D., Lexington, program chairman. The session will be held in connection with the annual meeting of the Kentucky Tuberculosis Association.

Doctor Cohn, in announcing the plans for the program, said: "Our goal is to cover a few selected topics in respiratory disease, but to cover them in depth. We feel that this will be a more stimulating and interesting type of program for the physicians in the state."

Speakers and their subjects are: Morris Scherago, M.D., "Leukocytic Hypersensitivity in Tuberculosis"; Hugh Fulmer, M.D., "Comparisons between Tine and Mantoux Tuberculin Tests"; Jerome Cohn, M.D., "Congenital Tuberculosis: Case Report"; Paul Chapman, M.D., "Current Trends in Tuberculosis"; Dean Davies, M.D., "Epidemiology of Bronchial Carcinoma"; Donald Paulson, M.D., Radiation and Surgery Combinations in Treatment of Lung Cancer"; Benjamin Rush, M.D., "Chemotherapy of Bronchogenic Carcinoma."

Nathan Levene, M.D., Louisville, is president of the Society.

KAGP Plans Annual Session At Louisville, May 7-10

The Kentucky Academy of General Practice will hold its annual meeting and 12th annual scientific session May 7-10 at the Kentucky Hotel, Louisville.

Doctor Greene

KAGP President J. Sankey Williams, M.D., will preside at the first scientific session May 8. David M. Cox, M.D., Louisville, President of the Kentucky State Medical Association and Doctor Williams will welcome the guests.

Speakers at the first scientific session will be, as follows: Laurence F. Greene, M.D, Rochester, Minn., "Office Urologic Procedures"; David B. Coursin, M.D., Lancaster, Pa., "Nutritional Problems of Infancy"; Joseph H. Shaffer, M.D., Detroit, "The Allergic Emergency—Aftermath of Modern Therapeutics"; Doctor Coursin, "Nutrition of the Adolescent".

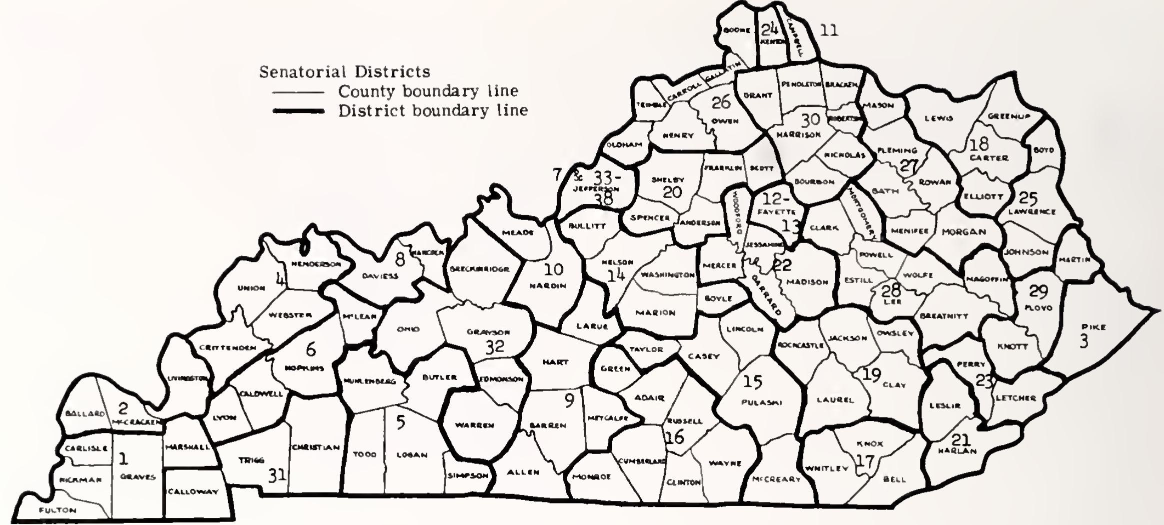
Speakers at the second scientific session May 9, presided over by Harry U. Whayne, M.D., Murray, president-elect, will include: Doctor Shaffer, "Stinging Insects—A Threat to Life"; Daniel B. Stone, M.D., Iowa City, "Hypoglycemia"; Leonard L. Lovshin, M.D., Cleveland, Ohio, "Tell-Tale Signs of Neurosis"; Doctor Greene, "Common Misconceptions Concerning Prostatism"; Eduard Eichner, M.D., Cleveland, Ohio, "Newer Concepts and Therapy in the Edema of Pregnancy"; Howard A. Andersen, M.D., Rochester, Minn. "Extra Pulmonary Manifestations of Bronchogenic Carcinoma"; Henry T. Bahnson, M.D., Pittsburgh, Pa., "The Surgical Treatment of Congenital Heart Disease"; Doctor Lovshin, "The Use of Methysergide in the Treatment of Vascular Headache."

Speakers at the third scientific session, which will be presided over by the new president-elect, will be as follows: Doctor Stone, "Management of the Diabetic Surgical Patient"; Doctor Eichner, "Control of Fertility"; Doctor Andersen, "Thoracic Pain and the Esophagus"; Doctor Bahnson, "The Treatment of Diseases of the Aorta and Great Vessels".

The annual banquet and installation of officers will take place on Thursday evening, May 9.

Doctor Noer on OSMA Program

Rudolf J. Noer, M.D., professor and chairman of the Department of Surgery at the University of Louisville School of Medicine, will be one of the guest speakers at the annual meeting of the Ohio State Medical Association annual meeting, May 12-17 at Cleveland. Doctor Noer will speak on "A Critical Review of Cancer of the Breast" at the sixth annual cancer conference presented at the annual meeting by the Ohio Division of the American Cancer Society.



Kentucky Senate and House Districts Reapportioned

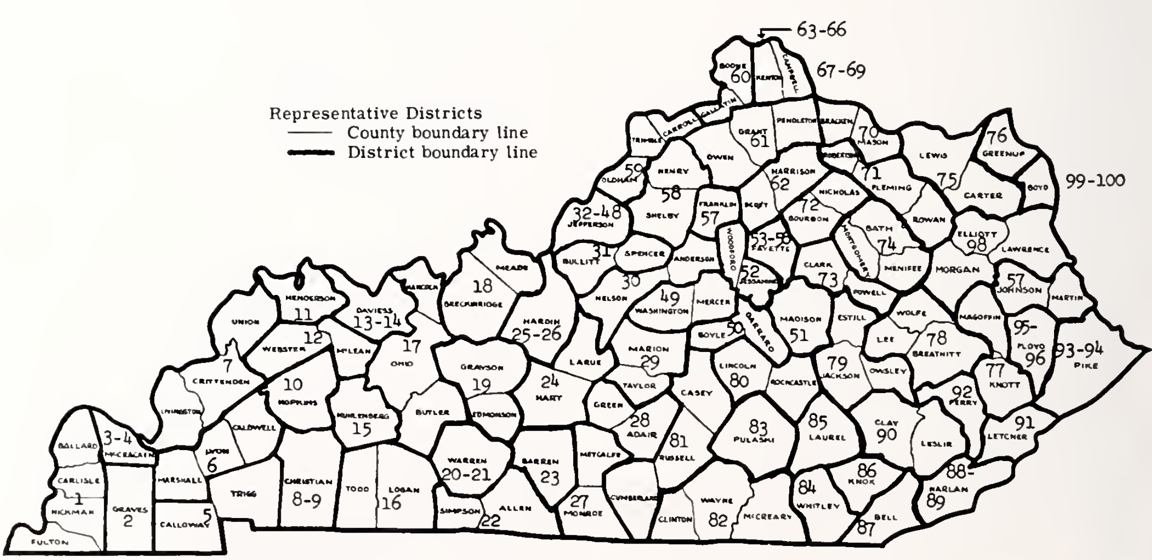
A special session of the Kentucky General Assembly was called January 28, 1963, by Governor Bert Combs to reapportion the Senate and House Districts and get them more equally populated. Kentucky's total population has changed very little since the 1940 census, but within the borders, the State has reflected the national shift of people from rural to urban areas.

The Constitutional requirement directing the General Assembly to reapportion the Senate and House Districts every 10 years has not been adhered to and mal-apportionment has been adjusted only three times in Kentucky history—1906, 1918 and 1942.

During this 1963 Special Session, Mitchel B. Denham, M.D., the only physician member in either house, introduced a bill which would have adhered to the Constitutional directive which says "not more than two counties shall be formed together to form a representative district." His bill received considerable support from rural legislators, however, it was not the one that finally passed the House.

All Senators representing counties in the newly-apportioned odd-numbered Districts will be selected in the November 5, 1963 general election. Those in the even-numbered Districts will serve until December 31, 1965. Since all representatives serve for two-year terms, all of them will be elected in November 1963.

If you desire further information regarding Kentucky's Representative and Senatorial Districts and the members who will represent them through the remainder of this year, please contact KSMA Headquarters Office.



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- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis

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EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*
Sulfaguanidine U.S.P. ... 2 Gm.
Pectin N.F. ... 225 mg.
Kaolin ... 3 Gm.
Opium tincture U.S.P. ... 0.08 cc.
(equivalent to 2 cc. paregoric)

DOSAGE: Adults: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

SUPPLIED: *Bottles of 16 fl. oz. (raspberry flavor, pink color)*
Exempt Narcotic. Available on Prescription Only.

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Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

Bernard Zimmermann, M.D., To Be Ky. Surgical Society Guest

Bernard Zimmermann, M.D., professor and chairman cf the Department of Surgery of West Virginia University Medical School, will be guest speaker at the annual meeting of the Kentucky Surgical Society May 17-18 at the Campbell House, Lexington. Doctor Zimmermann is a graduate of Harvard University Medical School and was professor of surgery at the University of Minnesota before going to West Virginia.

Doctor Zimmermann

Friday's program will be held at the University of Kentucky Medical Center and will be in charge of Ben Eiseman, M.D., Professor and Chairman of the Department of Medicine, and Frank Spencer, M.D. Friday morning speakers will be: John B. Floyd, Jr., M.D., "An Evaluation of Procaine Block in Experimental Pancreatitis"; William Gryboski, M.D., "Disaccharide Absorption and the Dumping Syndrome"; Lawrence Jelsma, M.D., "Hemobilia"; Thomas Moore, M.D., "Serotonin and the Dumping Syndrome"; Porter Mayo, M.D., "Early Treatment of Lung Abscess"; Lester Bryant, M.D., "Clinical Uses of Pulmonary Artery Puncture."

Friday afternoon: Doctor Spencer and E. Kent Carney, M.D., "Indication and Technique for Use of Artificial Pacemakers"; Doctor Spencer, "The Re-op Mitral"; Richard Crutcher, M.D., "Artificial Mitral Valve"; Nin Khiong Yong, M.D., "Experimental Coronary Artery Grafts"; Doctor Gryboski, "Surgical Therapy in Histoplasmosis"; Kampol Prachuabmoh, M.D., "Studies in the Heartless Dog"; Robert Lam, M.D., "Surgical Experience in the Narcotic Addict"; Howard Dorton, M.D., "Vagotomy and Pyloroplasty in the Treatment of Gastric Ulcer"; Rene Menguy, M.D., "Large Molecular Constituents of Gastric Juice"; Benjamin Rush, M.D., "Use of Arterial Infusion in the Treatment of Cancer."

Speakers at the Saturday morning session will be: J. Herman Mahaffey, M.D., Louisville, "Temporary Tube Gastrostomy"; W. Fielding Rubel, M.D., Louisville '"Cardiac Surgery"; and Doctor Zimmermann, "The Dynamics of Fluid Balance in Surgical Patients."

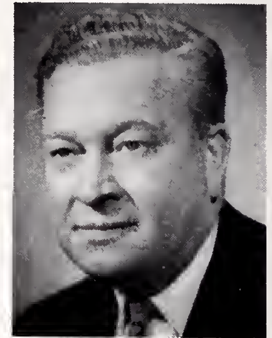
AMA Names Doctor Keeney

Arthur H. Keeney, M.D., Louisville, eye specialist, has been appointed to the Committee on the Medical Aspects of Automotive Safety of the American Medical Association. Doctor Keeney is chairman of the Highway Safety Committee of the Kentucky State Medical Association.

Kentucky Ob.-Gyn. Society to Hear Drs. Word, Hamblen, Hingson

Buford Word, M.D.; E. C. Hamblen, M.D., and Robert A. Hingson, M.D., are slated as guest speakers for the 16th annual meeting of the Kentucky Obstetrical and Gynecological Society at Lexington, May 9-11. Headquarters will be at the Campbell House Hotel.

George G. Green, M.D., Lexington, is president of the Society and James B. Stith, M.D., Lexington, is secretary-treasurer.



Doctor Word

Doctor Word is assistant professor of obstetrics and gynecology at the University of Alabama; Doctor Hamblen is professor of endocrinology at Duke University, and Doctor Hingson is chairman of the Department of Anesthesiology at Western Reserve University.

At the Thursday morning session, the report of the Maternal Mortality Committee will be given. Speaking at the afternoon session: Robert J. Griffin, M.D., Lexington, "Occiput Posterior"; John M. Baird, M.D., Danville, "L.S.M.F./C."; Doctor Hamblen, "The Newer Progesterones—Some Observations and Thoughts"; H. D. Chipps, M.D., Lexington, "Cytology of the Cervix—Experience in the Practice of General Pathology." A cocktail hour and buffet dinner will follow.

Friday morning the speakers will include: Harold J. Kosasky, M.D., Louisville, "Chromosomal Abnormalities in the Female"; C. M. Lacy, M.D., Owensboro, "Radical Pelvic Surgery in Women Under Age 30"; Doctor Hingson, "Anesthesia, with Special Reference to Fluothane." Friday afternoon Doctor Word will speak on "Gynecological Emergencies." Doctor Hamblen will discuss "Iatrogenic Pseudopregnancy." There will be a question and answer panel discussion, moderated by Laman Gray, M.D., Louisville. Participating: Douglas Haynes, M.D., Louisville, vice president of the Society; John W. Greene, M.D., Lexington, and Doctors Word, Hamblen and Hingson. Doctor Haynes is chairman of the Department of Obstetrics and Gynecology of the University of Louisville, and Doctor Greene holds a similar position with the University of Kentucky.

Doctor Word will be speaker for the Friday evening banquet, at which new officers will be installed.

The Saturday morning session will be held at the University of Kentucky Medical Center and the program will be provided by the U. of K. Ob.-Gyn Department, headed by Doctor Greene who will speak on "Measurements of Placental Function". "Initial Work Accomplished by Gyn. Group at University of Kentucky" will be told by Donald Edger, M.D., and Philip S. Crossen, M.D. Doctor Greene will then describe future plans for ob.-gyn. education at the U. of K.

U. of L. Reunions, Social Hour, Set For KSMA Meeting

The University of Louisville School of Medicine and the U. of L. Medical Alumni Association will sponsor their customary social hour and a banquet during the 1963 Annual Meeting of the Kentucky State Medical Association at the Phoenix Hotel, Lexington, September 23-26, according to J. Murray Kinsman, M.D., dean of the School, and Hoyt D. Gardner, M.D., Louisville, president of the alumni group.

The social hour and banquet will be held Tuesday evening, September 24, in the Crystal Ballroom of the Phoenix.

Plans are also being made, they said, for the annual alumni reunions of the following 10 classes of the School: Classes of 1913, 1918, 1923, 1928, 1933, 1938, 1943, 1948, 1953 and 1958.

David M. Cox, M.D., Louisville, president of KSMA, expressed the appreciation of the Association to the School and the Alumni Association and said that these functions occupy an unique position in the Annual Meeting program and are looked forward to by the many Kentucky physicians and U. of L. alumni who attend the KSMA Annual Meeting.

Mary Ellen Avery, M.D., To Address Kentucky Pediatricians

Mary Ellen Avery, M.D., Johns Hopkins Hospital, will be guest speaker for the joint meeting of the Kentucky Pediatric Society and the Kentucky Chapter of the American Academy of Pediatrics, according to Noble T. Macfarlane, M.D., Lexington, president of the Society.

The meeting will be held May 22-23 at Lexington.

Doctor Avery will discuss the respiratory distress syndrome at one session and resuscitation of the newborn at another. There will also be either a clinicopathological conference or case presentations by the University of Kentucky Pediatrics Department.

Social activities will include a dinner each evening at the Campbell House; a golf tournament, and for the non-golfers a tour of the U. K. Medical Center.

Results of Glaucoma Screening at 1962 State Fair Reported

At the Glaucoma Screening Project undertaken at the 1962 State Fair, during which 36 Kentucky ophthalmologists cooperated in the program, 4,370 persons were screened, according to C. Dwight Townes, M.D., chairman of the Professional Advisory Committee to the Kentucky Society for the Prevention of Blindness.

The Society sponsored the project in cooperation with the Kentucky State Medical Association, the Kentucky State Department of Health, the U. S. Public Health Service and the Department of Ophthalmology of the University of Louisville School of Medicine.

According to Doctor Townes, of the 4,370 people screened, 331 were found to be suspects and were referred to their own ophthalmologists for definitive diagnostic examinations. As of February 15, 1963, he said, 83.6% of those referred for diagnostic examinations had seen their personal eye physicians and 83 previously unknown cases of glaucoma are now under treatment.

Plans are now being made to sponsor the screening project at the 1963 State Fair, September 6-14. It is expected that the public response will be even larger this year, Doctor Townes said, and it is hoped that 54 of the State's ophthalmologists will volunteer their services. Response of eye physicians to requests to aid the project have been very encouraging, he added.

Current Problems of Medicine Told at Interim Meeting

A broad yet detailed picture of the medical profession in the current social, political and legislative scene was given to those attending the 13th Annual Interim Meeting of the Kentucky State Medical Association at Covington, March 7, by an array of effective speakers. (See pictures on pages 356 and 361.)

KSMA President David M. Cox, M.D., Louisville, presided at the morning session and George P. Archer, M.D., Prestonsburg, president-elect, at the afternoon session.

Karl C. Jonas, M.D., a member of the Physicians Review Board of the Philadelphia Blue Cross, outlined the physician's relationship to voluntary health insurance and called it the first line of defense of the profession against socialization.

Ever Curtis, M.D., Gloucester, Mass., a member of the AMA National Speakers Bureau, urged her listeners to be careful in the selection of their representatives in Congress when voting and to tell the people the true facts of the dangers inherent in current proposals in Congress to enact a system of medical care under Social Security.

A history of AMPAC and how it operates was presented by Milton V. Davis, M.D., Dallas, Texas, secretary-treasurer of AMPAC. He complimented Kentucky physicians on the splendid performance of KEMPAC.

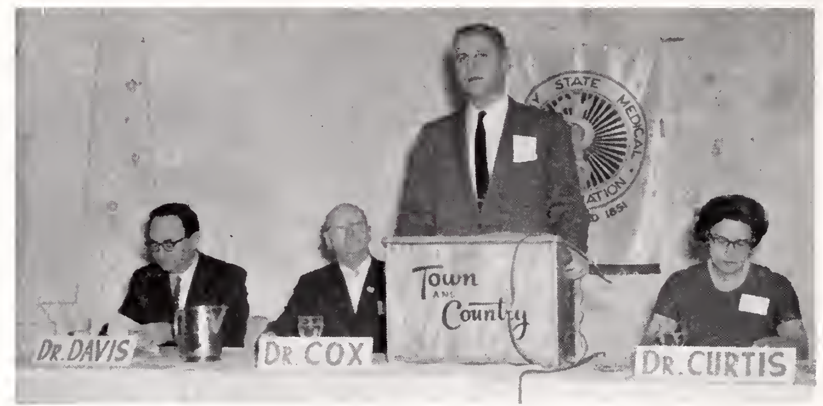
The Luncheon speaker was the Rev. Dr. William W. Slider, minister of the Christ Methodist Church, Louisville.

At the afternoon session, Burl St. Clair, Falls of Rough, immediate past president of the Kentucky Farm Bureau, spoke on "Opportunity vs. Security".

K. C. of C. Names Dr. Simpson

Gaithel L. Simpson, M.D., Greenville Ky., immediate past president of the Kentucky State Medical Association, was one of 17 new directors elected by mail ballot for three-year terms by the Kentucky Chamber of Commerce.

Picture Story of the KSMA Interim Meeting at Covington, March 7



Karl C. Jonas, M.D., (top picture, third from left) addresses the Interim Meeting of the Kentucky State Medical Association at Covington, March 7. Seated at the speakers table for the morning session are, left to right, Milton V. Davis, M.D., Dallas, Tex., guest speaker; David M. Cox, M.D., Louisville, KSMA president, and Ever Curtis, M.D., Gloucester, Mass., guest speaker.

Guest speakers and officers (middle picture), left to right, Guest Speaker Burl St. Clair, Falls of Rough, immediate past president of the Kentucky Farm Bureau Federation; KSMA President Cox; George P. Archer, M.D., Prestonsburg, KSMA president-elect; the Rev. Dr. William W. Slider, Louisville, luncheon speaker; Wilbur R. Houston, M.D., president of the Campbell-Kenton County Medical Society.

KSMA President Cox confers with Student AMA leaders at the Interim Meeting (bottom picture), left to right, Jerry B. Buchanan, Louisville, president of the U. of L. Chapter; President Cox; Mrs. Shirley A. Moore, secretary, and Max Kimball, treasurer of the U. of K. Chapter.

* * * *

Kentucky State Association of Medical Assistants

First Annual Convention

May 18 - 19

Kentucky Hotel, Louisville

Your medical assistant will be more valuable to you if you encourage her to attend this meeting.

KSMA Council on Medical Services Reports on Its Study of Self-Employed Individual Tax Retirement Act of 1962

THE "SELF-EMPLOYED Individual Tax Retirement Act of 1962" was signed into law by the President on October 10, 1962.

Since that time, the Council on Medical Services of the Kentucky State Medical Association has been gathering information and making studies to determine if and how best this law can benefit the members of KSMA.

To implement this "skeleton" law, the Treasury Department must compile and promulgate certain rules and regulations pertaining to the drafting of a qualified retirement plan. Therefore, the Council feels it is highly inadvisable at this time for any self-employed person to rush into a retirement plan, not knowing whether or not his plan can comply with rules and regulations or whether his contributions to such a plan would be deductible for income tax purposes. In order to obtain his tax deduction for the year 1963, a self-employed individual has until December 31, 1963, to establish and qualify plans.

Some of the important highlights of the law are as follows: (1) You must be self-employed to be eligible. (2) You may set aside 10% of your earned income, up to $2,500 a year, for a retirement fund. (3) You can contribute less than 10% of your earnings and you do not have to contribute to the fund each year. (4) You must include any employees who work for you three years or longer in the retirement program. (5) Each year you can deduct one half of the contributions made to the retirement fund from your gross income for income tax purposes.

(6) The earliest you may start drawing benefits from your fund is when you are 59½ years old. (The exceptions to this are in cases of disability or death. A financial penalty is incurred for withdrawing the money at an earlier age) (7) You may postpone retirement and the drawing of the fund benefits until you are 70½ years old, but not later. (8) Your funds may be invested in one of the following ways: (a) Trusteed plan. The contributions to the plan are turned over to the bank as trustee who can invest them in stocks, bonds, mutual funds, etc. (b) Insurance and Annuity plan. (c) Special mutual funds plan. (d) Purchase of special new issue of U. S. Bonds

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One of Ten U. S. Medical Students Has Borrowed from AMA-ERF

Nearly one of every 10 medical students in the country now has borrowed money under the American Medical Association's Education and Research Foundation Loan Guarantee Program, according to a recent progress report covering the first 10 months of the program.

Thirty-six loans totaling $38,800 have been made to 31 students at the University of Kentucky College of Medicine, Lexington, while 49 University of Louisville medical students received $65,500 in loans. Fourteen students at neighboring University of Cincinnati School of Medicine have received $18,700 and Vanderbilt medical students had two loans granted totaling $3,000. The highest number of loans, 172 totaling $222,500, were made to medical students at Loma Linda University, Los Angeles.

The success of this program was outlined by Gerald D. Dorman, M.D., New York, member of the AMA Board of Trustees, when he appeared before the Interstate and Foreign Commerce Committee of the U.S. House of Representatives February 7, 1963, to make AMA's statement on H.R. 12. Health Professions Educational Assistance Act of 1963. Part of this bill amends the Public Health Service Act to provide matching grants for construction of medical, dental, and osteopathic schools and an appropriation to establish a loan fund for medical, dental and osteopathic students.

Doctor Dorman said: "This AMA-ERF Program indicates the extent to which private enterprise and efforts can solve important problems without the necessity of calling on the federal government for tax funds. We are firmly convinced that governmental assistance to medical education should give first priority to providing necessary, needed funds for medical school construction."

Applicants for loans must be U. S. citizens in training and in good standing in an AMA-approved medical school or hospital.

If the present rate of borrowing continues, some 7,200 loans will be made in 1963.

Tax Relief for Casualty Loss

A relief provision in the income tax law, effective in 1962, provides that individual taxpayers who suffer casualty losses between January 1, 1963 and April 15, 1963, may claim these on their 1962 federal income tax returns, according to District Director of Internal Revenue G. C. Hooks, Louisville, Ky. Mr. Hooks emphasized that this relief provision pertains only to areas which have been proclaimed disaster areas by the President. The extensive losses experienced in the 1963 spring floods in eastern Kentucky would thus be covered. The losses may be claimed either in the 1962 or the 1963 returns, he said.

POSED BY MODELS

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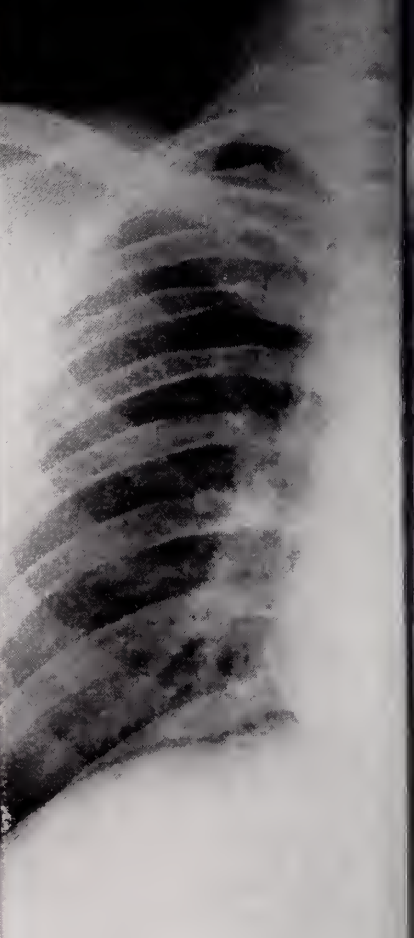

all things considered

in bronchitis—Considering the pattern of mixed bacteria, localized or diffuse involvement, potential underlying disease, and the need to allay symptoms and ease respiratory/cardiac function...physicians often include DECLOMYCIN demethylchlortetracycline in the course of therapy.

DECLOMYCIN produces activity levels higher than those of other tetracyclines...at lower dosage...and maintains them during the entire course of treatment without significant fluctuation.

This activity is prolonged 24 to 48 hours after the last dose, helping to protect against relapse.

Over the wide range of everyday infections—respiratory, urinary and most others—in the young and the aged—the acutely or chronically afflicted—DECLOMYCIN provides the "extra dimension" in broad spectrum control.

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For *adults: Capsules*, 150 mg. and 75 mg. For *children:* cherry-flavored *Pediatric Drops*, 60 mg./cc., and cherry-flavored *Syrup*, 75 mg./5 cc. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

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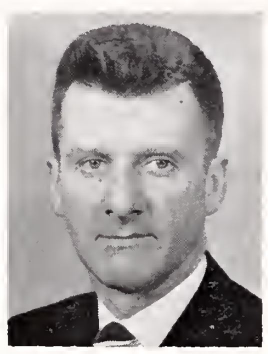
MEDICAL SCHOOL NEWS

Doctor Falkner Heads U. of L. Pediatrics Department

Frank T. Falkner, M.R.C.P., M.R.C.S., Louisville, has been named chairman of the Department of Pediatrics of the University of Louisville School of Medicine. Dr. Falkner has been serving as acting head of the Department since Alex J. Steigman, MD., resigned last year to head a child-health research project at Evanston, Illinois.


Doctor Falkner

Doctor Falkner went to the U. of L. in 1956 directly from London, England where he had received his medical education and had previously practiced.

The appointment also makes Doctor Falkner head of pediatrics at the Louisville General Hospital and Children's Hospital. He is a graduate of Cambridge University and the London Medical College.

Immediate efforts will be made, Doctor Falkner said, to increase the teaching staff of the Pediatrics Department and to develop pediatrics at Children's Hospital, Louisville, now the major pediatric-teaching institution for the U. of L. School of Medicine. Doctor Falkner's appointment has made it necessary for him to postpone a trip to Nigeria to help plan a 200-bed hospital and a trip to London to accept appointment as a member of the Royal College of Physicians.

The U. of L. School of Medicine has received a $75,000 grant from the National Institute of Mental Health to provide postgraduate training in psychiatry for a group of Louisville area physicians, according to Warren Cox, M.D., director of the Louisville Area Mental Health Center. Between 10 and 15 physicians will participate in the program each year, Doctor Cox said.

Presley F. Martin, M.D., Louisville, is program director. Other Louisville psychiatrists participating are: Harold L. McPheeters, M.D., state mental health commissioner; S. Spafford Ackerly, M.D., chairman of the U. of L. Department of Psychiatry; Frank M. Gaines, Jr., M.D.; Hollis Johnson, M.D., and Frederick C. Ehrman, M.D. Doctor Gaines is chairman of the KSMA Mental Health Committee.

Thomas F. Whayne, M.D., Named By U. of K. Medical Center

Thomas French Whayne, M.D., has been appointed assistant vice president for the University of Kentucky Medical Center and professor of community medicine. Doctor Whayne, a native of Columbus, Ky., is a 1931 graduate of Washington University Medical School, St. Louis, Mo. He holds the degrees of master and doctor of public health from Harvard University. He was formerly associate dean of the medical college of the University of Pennsylvania.

William Ernest Bakewell, Jr., M.D., has been named assistant professor in the Department of Psychiatry. Doctor Bakewell received his M.D degree from McGill University.

The University of Kentucky Medical Center reports $1,070,000 currently being spent for research.

The U. of K. Surgery Day will be April 18 with the topic: "Cancer Surgery".

The Department of Pediatrics postgraduate day monthly session will be April 26 and will include grand rounds, basic science discussion and subspecialty rounds.

Rudolf J. Noer, M.D., professor and chairman, Department of Surgery, University of Louisville School of Medicine, will be third lecturer in the Cancer Teaching Lecture Series at the U. of K. Medical Center. He will speak April 11 on "Chemotherapy of Neoplasms".

A course in "Recent Advances in Clinical Cardiology" will be offered by the U. of K. College of Medicine May 9-11.

Student AMA

KSMA Interim Meeting Impresses U. of L. SAMA President

After the 13th Annual Interim Meeting of the Kentucky State Medical Association on the seventh of last month, my feelings were mixed. These feelings concerned the political future of our treasured profession. I felt a little more secure, a little more confident, even a little happier because of the calibre of prepared people we have speaking and fighting for us; but at the same time, I felt ashamed because I had not been doing my part.

We, the medical students, are to be affected more than anyone else by future legislation, and we, more than anyone else it seems, have assumed a passive attitude concerning our political future. My fellow medical students, we are fighting for our very professional lives—unlike our opponents, we can lose only once.

The purpose of this article is to stress the gravity of the problem we face. We are well aware of the reasons and arguments for the stand which we take, but are we doing all we can to make others aware of them? Are we stressing the fact that when individual freedom is taken from the doctor he will be unable to serve the American people to the best of his ability and thus the American people as well as the doctor will suffer?

Are we discussing the situation with our colleagues; are we talking to our friends outside the medical profession about it, and are we stressing the severity of the problem with our daily contacts in our work? Are we ready and do we have others ready to write to their respective Congressmen at the appropriate time?

Grant you, this isn't a lot, but it is a start. Remember: "Silence is probably our worst enemy."

Jerry B. Buchanan, President
U. of L. Chapter, SAMA

Mrs. Jo Rich, Lexington, president of the Woman's Auxiliary to the Kentucky State Medical Association, presents a letter of appreciation to J. P. Sanford, executive secretary of KSMA, extending the thanks of the Auxiliary to the KSMA Headquarters staff for their cooperation with the Auxiliary. The presentation took place during the luncheon session of the Interim Meeting at Covington, March 7.

Chest Physicians To Meet June 13-17

The American College of Chest Physicians will hold its annual meeting June 13-17 at the Ambassador Hotel, Atlantic City. Among subjects to be discussed during the meeting: Relationship of Autoimmunity to Cardiopulmonary Disease; Transplantation of Tissues and Organs; Cardiac Rehabilitation; Pediatric Cardiology; Management of the Cardiopulmonary Cripple; Mycobacterial Diseases of the Chest; Bronchogenic Carcinoma; Anticoagulant Therapy; Air Pollution, and Hyperbaric Oxygen Therapy.

Doctor Greathouse Cited

Richard F. Greathouse, M.D., Louisville pediatrician and president of the staff at Children's Hospital, recently received an honor in another field. Doctor Greathouse, who is president of the Collie Club of America, was cited in absentia at the annual awards dinner in New York City of the Dog Writers Association of America, as publisher of The Collie Bulletin, which won the prize as the best breed publication of 1962. Doctor Greathouse was prevented by bad flying weather from reaching New York in time for the presentation.

News of Mycetism Deaths Sought

The National Registry of Deaths from Mycetism, which maintains a file of deaths attributable to ingestion of wild mushrooms, requests physicians to send notice of all such deaths (age, sex, date, locality) to: Robert W. Buck, M.D., Secretary, Massachusetts Medical Society, 22 The Fenway, Boston 15, Mass.

Each dollar you give to the AMA-ERF Student Loan Fund creates $12.50 in guaranteed loan power. Help build this Fund by sending your check today to 535 North Dearborn Street, Chicago 10, Illinois.

Dr. Griswold Elected by Surgeons

R. Arnold Griswold, M.D., Louisville, was elected vice president of the Southeastern Surgical Congress at the annual meeting at Miami Beach the week of March 18, according to a report from J. Duffy Hancock, M.D., Louisville, councilor for Kentucky. There was an excellent representation from Kentucky, Doctor Hancock said.

Papers were read at the meeting by Doctor Griswold and by Charles F. Wood, M.D., Louisville. The following discussed papers: John A. Hemmer, M.D.; John H. Jurige, M.D., and Thomas E. Booth, M.D., all of Louisville. Mrs. C. M. Bernhard, Louisville, was named president-elect of the Woman's Auxiliary to the Congress.

Anesthesiologists To Meet in May

The Kentucky Society of Anesthesiologists will hold its quarterly meeting at Lexington, May 11-12, with Robert B. Sweet, M.D., professor and chairman of the Department of Anesthesiology of the University of Michigan, as main speaker. A social affair will be held the evening of the 11th. The business meeting of the Society will begin at 11 a.m., May 12, at the Phoenix Hotel, to be followed by the luncheon and afternoon session at which Doctor Sweet will speak.

New Program for State Hospitals

A new program to evaluate all mental patients' vocational needs and potentialities and then provide the services necessary for vocational rehabilitation is being worked out in Kentucky's state mental hospitals by the Department of Mental Health and the Bureau of Rehabilitation Services of the State Department of Education. Heretofore, according to Harold L. McPheeters, M.D., state mental health commissioner, only a small number of patients were reached with the limited vocation rehabilitation programs available.

TB Death Rate in Kentucky Drops

Tuberculosis has dropped to 12th place among causes of death in Kentucky, according to figures for 1961, reported M. Stuart Lauder, M.D., director of tuberculosis control for the State Department of Health. This is the first time tuberculosis has not been among the leading 10 causes of death in the Commonwealth. In 1957, the TB death rate was 14.9 per 100,000; in 1961, it was 10.1 per 100,000—still higher than the national rate of 6.5 in 1959.

Medical students, interns and residents being aided by loans guaranteed by the AMA-ERF student loan program are in training in nearly every medical school and in 400 hospitals in almost every state in the Union. One in three comes from a family in which the father is retired, disabled or deceased.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

In Kentucky

APRIL

9-11 Kentucky Public Health Association, Annual Meeting, Kentucky Hotel, Louisville, Ky.

18 Monthly University Surgical Day, "Cancer Surgery," University of Kentucky Medical Center, Lexington, Ky.

24 Kentucky Psychiatric Association, Holiday Inn, Lexington, Ky.

25-26 "Thoracic Diseases," University of Kentucky Medical School, Lexington, Ky.

26 Department of Pediatrics, Postgraduate Day Monthly Session, University of Kentucky Medical Center, Lexington, Ky.

MAY

8-10 Kentucky Academy of General Practice, Annual Meeting, Kentucky Hotel, Louisville, Ky.

8-10 Kentucky Obstetrical and Gynecological Society, Annual Meeting, Campbell House, Lexington, Ky.

9-11 "Cardiology," University of Kentucky Medical Center, Lexington, Ky.

11-12 Kentucky Society of Anesthesiologists, Phoenix Hotel, Lexington, Ky.

15-16 Kentucky Pediatric Society and Kentucky Chapter, American Academy of Pediatrics, Lexington, Ky.

16 Monthly University Surgical Day, "Surgical Physiology," University of Kentucky Medical Center, Lexington, Ky.

17-18 Kentucky Surgical Society, University of Kentucky Medical Center, Lexington, Ky.

22-23 Kentucky Pediatric Society, University of Kentucky Medical School, Lexington, Ky. (22nd: Respiratory Distress Syndrome; 23rd: Resuscitation of the Newborn)

Surrounding States

APRIL

12-13 Hemodynamic Effect of Anesthesia, Ohio State University College of Medicine, Columbus, Ohio.

14 Pediatrics in General Practice, Southwest Ohio Society of General Physicians, Academy of Medicine, Cincinnati, Ohio.

21-24 American College of Obstetricians and Gynecologists, Statler Hilton Hotel, New York, N.Y.

22-24 American Academy of Pediatrics, Statler Hilton Hotel, Los Angeles, Calif.

23-24 Non-tubercular Problems of Pulmonary Medicine, Marion County General Hospital, Indianapolis, Ind.

26-28 American College of Pathologists and Bacteriologists, Cincinnati, Ohio.

MAY

1-2 Ninth Annual Seminar, Cancer-Emphasis on Chemotherapy, Huron Road Hospital, Cleveland, Ohio.

3-4 American Pediatric Society, Seaside Hotel, Atlantic City, N.J.

13-15 American Gynecological Society, Roosevelt Hotel, New Orleans, La.

15 Medical Treatment of Malignancy, Indiana University Medical Center, Indianapolis, Ind.

16 Medical Problems in Renal Disease, Indiana University Medical Center, Indianapolis, Ind.

20-24 Cardiopulmonary Disease: American College of Physicians Course, Indiana University Medical Center, Indianapolis, Ind.

JUNE

13-17 American College of Chest Physicians, Ambassador Hotel, Atlantic City, N.J.

17-21 5th Annual refresher course in Diagnostic Roentgenology, University of Cincinnati College of Medicine, Cincinnati, Ohio.

16-20 Annual Meeting, American Medical Association, Auditorium & Convention Hall, Atlantic City, New Jersey

24-27 American Orthopaedic Association, The Homestead, Hot Springs, Va.

24-28 Internal Medicine: Current Physiological Concepts in Diagnosis and Treatment, American College of Physicians Course, Cincinnati General Hospital and University of Cincinnati College of Medicine, Cincinnati, Ohio.

SEPTEMBER

23-26 KSMA Annual Meeting, Phoenix Hotel, Lexington, Ky.

Put your low-back patient back on the payroll

Soma relieves stiffness –stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. USUAL DOSAGE: 1 TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey

In Memoriam

CARLOS ALBERT FISH, M.D.
Louisville
1910-1963

Carlos Albert Fish, M.D., 52, Louisville internist, died March 18 at Norton Memorial Infirmary. Doctor Fish was an associate professor of medicine at the University of Louisville School of Medicine. He was graduated from the U. of L. with an M.D. degree in 1936; in 1938 he received a clinical fellowship in medicine at the University of Pennsylvania Hospital. Doctor Fish served as a lieutenant colonel in the Army Medical Corps in World War II for almost five years and was awarded the Legion of Merit.

FARRIS L. ALLEN, M.D.
Ashland
1881-1963

Farris L. Allen, M.D., 81, Ashland, eye, ear, nose and throat specialist, died February 16 at St. Mary's Hospital, Huntington, W. Va., after a brief illness. Doctor Allen was graduated from the old Kentucky School of Medicine at Louisville in 1906 and from the Chicago Eye, Ear, Nose & Throat College in 1919.

PHILIP J. MALAGRINO, M.D.
Louisville
1900-1963

Philip J. Malagrino, M.D., 62, Louisville, general practitioner, died at his home February 14. Doctor Malagrino practiced in New York City and for eight years at Sacramento, Ky., before moving to Louisville two years ago. He was a graduate of the New York University College of Medicine.

GEORGE EUGENE LOWREY, M.D.
(Formerly) Harrodsburg
1908-1963

George Eugene Lowrey, M.D., 54, Butlerville, Ind., who practiced medicine at Harrodsburg, Ky., for 20 years before moving to Indiana, died suddenly at his home. Doctor Lowrey was graduated from the University of Louisville School of Medicine in 1934 and was acting clinical director of the Muscatuck State School at Butlerville at the time of his death.

WILLIAM CHESLEY KEMP
Providence
1884-1963

William Chesley Kemp, 78, Providence, Ky., retired general practitioner, died March 4 at his home. Doctor Kemp, who practiced medicine in Webster County for 55 years mostly at Dixon, moved to Providence two years ago. He retired from active practice in 1960. He was a 1906 graduate of the old Hospital College of Medicine, Louisville.

MORRIS M. WEISS, SR.
Louisville
1901-1963

Morris M. Weiss, Sr., 62, Louisville cardiologist, died of a heart attack February 25 while making a house call on a patient. Doctor Weiss was graduated from the University of Louisville School of Medicine in 1925 and served his internship and residency at Montefiore Hospital, New York City. He began his practice in Louisville in 1928. He was also associate professor of medicine at the U. of L. A son, Morris M. Weiss, Jr., was associated in medical practice with him.

Memorial to Dr. W. O. Johnson

In a ceremony March 9, commemorating the late William O. Johnson, M.D., who died February 5, 1960, the Department of Obstetrics and Gynecology of the U. of L. School of Medicine received a $10,000 bequest from Doctor Johnson's estate. The bequest will be used to equip a research laboratory for the Department in the new Medical-Dental Research Building in the U. of L. Medical Center.

At the ceremonies, a plaque was presented to the Medical School from the Southern Society of Clinical Surgeons in recognition of Doctor Johnson's 35 years on the medical faculty. He served as professor and chairman of the Department of Obstetrics and Gynecology from 1947-1957.

In The Books *(Continued from page 310)*

tain the original spelling and dialect of the writings of Henry Clay Lewis, for it is as much in the manner of writing as in the story told, that one recognizes the charm and talent of this physician-humorist. Reading these stories written in dialect is not easy, however.

The busy physician may find welcome relaxation in reading this book, or he may find here a new and quite different literary interest.

Eugene H. Conner, M.D.

County Society Reports

McCracken

Frank Crawford, M.D., radiologist at the Lourdes Hospital, Paducah, presented the scientific program on "Hiatus Hernia" at the February 27 meeting of the McCracken County Medical Society. Doctor Crawford used radiographs and discussed the anatomy, physiology and clinical findings in a number of cases. A general discussion followed his presentation.

At a business session following the scientific program it was decided that the executive committee of the Society should review procedure for selecting a Key Man for the county and clarify his duties.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1963 Annual Meeting — Kentucky State Medical Association

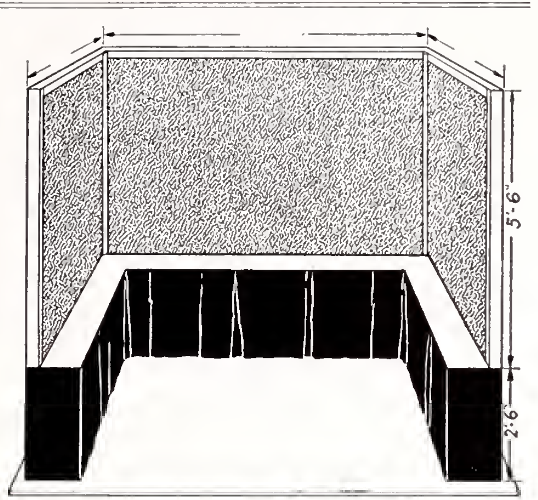
Phoenix Hotel — **Lexington, Kentucky** — **September 23, 24, 25, 26**

Fill Out and Mail to:

J. ALEX HALLER, M.D., Chairman
Committee on Scientific Exhibits
Department of Surgery
University of Louisville
511 S. Floyd Street
Louisville 2, Kentucky

Applications for space should be received before July 1, 1963

Dimensions and structure of KSMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: ....
2. Name (s) of Exhibitor (s): ....
   ....
   Institution (if desired): ....
   Mailing Address ....
3. Do you have a built-in exhibit? ....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)
   Charts and Posters.... Photographs.... Drawings.... X-rays....
   Specimens.... Moulages.... Other Material .... (Describe)
6. Booth Requirements:
   Amount of wall space needed? ....
   Back wall .... Side walls ....
   Square feet needed? ....
   Shelf desired? (yes or no) ....
7. Has This Exhibit Been Exhibited Before? (yes or no) ....

Date ....
Signature of Applicant

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KSMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

"All tied up"—and ready to go to the Scout-O-Rama at the Kentucky State Fairgrounds, April 26-27, is Jim Mory, Louisvile, 11 years old and a second class scout. The display of many Scout activities is open to the public and sponsored by the Rotary Club of Louisville. Participating are scouts from 19 counties who comprise the Old Kentucky Home Boy Scout Council.

Doctor Coe on Heart Radio Program

Walter S. Coe, M.D., Louisville, president of the Heart Association of Louisville and Jefferson County, took part in a radio question-and-answer program concerned with heart disease on Radio Station WHAS February 8. Doctor Coe is also associate editor of The Journal of KSMA.

Five Ob.-Gyn. Fellows Named

Five Kentucky physicians were among the 587 new Fellows inducted into the American College of Obstetricians and Gynecologists. Joseph F. Daugherty, M.D., Florence; Herbert L. Kotz, M.D., Ft. Campbell; Philip S. Crossen, M.D., Lexington; Joseph J. Lee, M.D., and William E. Pugh, M.D., Louisville.

Dr. Murphy on AMA Committee

Owen B. Murphy, M.D., Lexington, has been reappointed a member of the Committee on Medical Aspects of Sports of the American Medical Association. Doctor Murphy is a member of the KSMA School Health Committee.

Dr. Harold Jacobson To Speak

Harold Jacobson, M.D., professor of clinical radiology, New York University College of Medicine, will deliver the 15th annual Joseph and Samuel Freedman Lectures in diagnostic radiology April 27-28 at the University of Cincinnati College of Medicine. Doctor Jacobson is also chief of the Division of Diagnostic Radiology at Montefiore Hospital. For further details write: Benjamin Felson, M.D., Department of Radiology, Cincinnati General Hospital.

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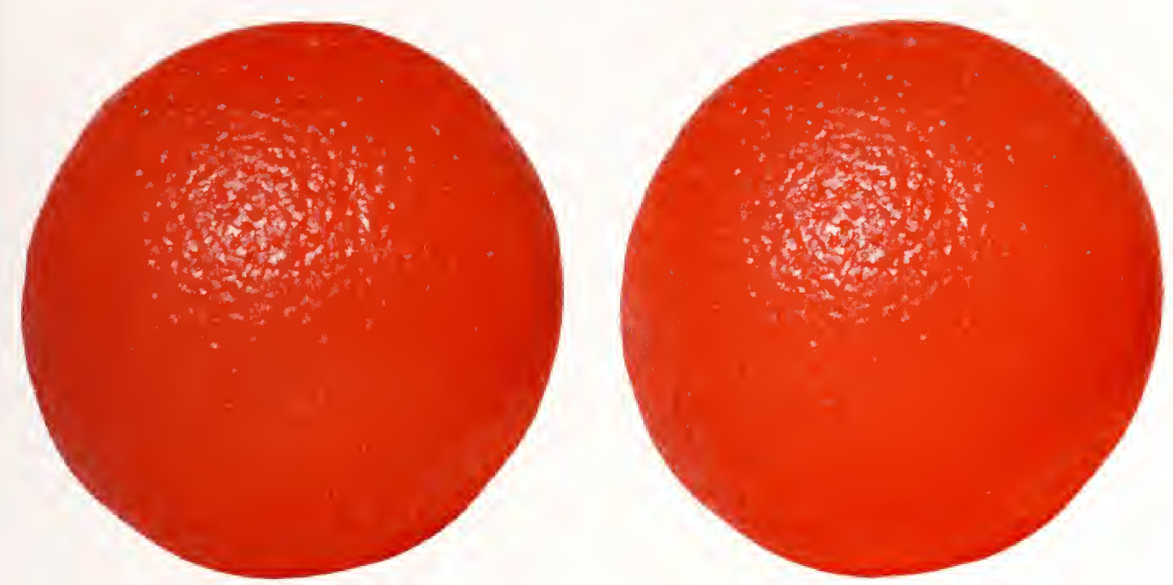

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3 Named to Hospital Council

William T. McElhinney, M.D., Covington; Richard F. Grise, M.D., Bowling Green, and Willis P. McKee, M.D., Shelbyville, February 20 were named members of the Kentucky State Advisory Council on Hospital Licensure by Governor Bert T. Combs. The terms of Doctors McElhinney and Grise will end in July 1963 and that of Doctor McKee in July 1964.

New KSMA Members Reported

The following have recently become members of the Kentucky State Medical Association: David Collins, M.D.; Donald Potts, M.D., and Waldo Williams, M.D. — all of Louisville; Tom Wilson, M.D., and William M. Wyatt, M.D., Somerset; J. K. Hurlocker, M.D., Harlan, and Elmer A. Gearhart, M.D., Owensboro.

Trudeau School To Be June 3-21

The 48th session of the Trudeau School of Tuberculosis and Other Pulmonary Diseases will be held in Saranac Lake, N.Y., June 3-21. Tuition is $100 for the three-weeks session. For more information write: Secretary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 670, Saranac Lake, N.Y.

* * *

Private industry has donated more than $425,000 to the AMA-ERF Student Loan Fund. This support, together with generous contributions from physicians, has made it possible for thousands of medical students, interns and residents to obtain low-interest bank loans to help finance their medical education.

Named Hospital Administrator

Cardin W. Carmack, formerly assistant administrator at Outwood Hospital, Dawson Springs, has been named administrator of the hospital and school for the retarded at Kentucky Training Home, Frankfort.

Hospital Alumni Plan Meeting

The University of Louisville Hospital Alumni Association will hold its annual meeting and dinner June 6.

Hospital at Jenkins Closes

The Sharon Heights Hospital at Jenkins, Ky., closed March 7, according to published reports. The 45-bed hospital was operated for a number of years by the Sisters of Divine Providence, an order of Catholic nuns.

Blood Banks Group To Meet May 18

The Kentucky Association of Blood Banks will meet May 18 at 2:30 p.m. in the auditorium of the St. Joseph Infirmary, Louisville. There will be a scientific program, adoption of a constitution and election of officers.

* * *

The year 1963 marks the 100th Anniversary of the World Red Cross movement.

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News Items

Oliver Ralph Roth, M.D., has joined **Walter L. Cawood, M.D.,** at Ashland, Ky., in the practice of radiology. Doctor Roth is a 1950 graduate of the University of Maryland Medical School and interned at Mercy Hospital at Baltimore. He was in residency at Johns Hopkins Hospital for three years and was also an American Cancer Society Fellow at the Middlesex Hospital in London, England. Doctor Roth was in general practice at Cumberland, Md., from 1951 to 1954 and practiced radiology in Charlotte, N. C., 1958-1962.

Richard E. Geist, Ashland, Ky., a junior in the University of Kentucky College of Medicine, Lexington, is one of 31 U.S. medical students to obtain foreign fellowships enabling them to obtain supervised medical experience in underdeveloped countries. Mr. Geist will go to Iran. The fellowships are awarded by the Association of American Medical Colleges and made possible by a grant from Smith Kline & French.

Robert H. Scobee, M.D., Winchester, received a special letter of recognition on the occasion of his retiring December 31, 1962, after over 35 years of active practice. The letter was sent to Doctor Scobee by the board of the Clark County Hospital Association

* * * *

"Will this (new drug) law and the regulations hurt journal advertising? It is difficult at this point for me to give a categorical answer to this question. Certainly, we are not going to stop advertising. The requirement that we give a brief summary relating to side effects, contraindications and effectiveness will not deter manufacturers from advertising provided the regulations are reasonable. However, there is one respect in which I am afraid all advertising will be affected. Our largest advertising budgets are devoted to the promotion of new products. In my opinion, present administrative procedures and the requirements of the new law will indisputably slow down the development and marketing of new drugs, which means that each year we will have fewer new drugs to advertise. However, as an offset against this, having invested more in the development of a new drug, we will be willing also to invest more in its promotion because we can't take a chance of faltering in this final payoff step. And, it is entirely possible that the net effect on journal advertising will be unchanged in the long run." — Theodore G. Klumpp, M.D., president, Winthrop Laboratories, in *Rocky Mountain Medical Journal,* December 1962.

* * * *

A contribution of $100 to the Student Loan Guarantee Fund of AMA-ERF generates $1,250 in medical education loan-power—enough to help the average student pay for a year's training. Your donation, mailed to 535 North Dearborn Street, Chicago 10, Illinois, *can* help insure the continued high standards of American medicine by removing financial barriers for capable young people.

The 750 insurance companies licensed to operate in the State of Kentucky did a premium volume business in the State of $393,025,940 and paid $7,054,442.21 in taxes and fees. Only $324,320.78 was spent to operate the State Insurance Department, or 4.6% of taxes and fees collected.

"We are all too human—members of the health professions, drug manufacturers, advising agencies, sick people, and all the rest of us who are trying to live happily—and often our emotions get in the way of our good sense. When it comes to drugs, it might be wise to let the experts in the field tell us what it's all about, and then use our own good judgment in deciding whether the risk of the drug outweighs the risk of the disease. There is risk both ways, and this we must understand."—Chauncey D. Leake, Ph.D. in *Medical Tribune.*

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June 16-20

on

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Answers To Questions About Your

BLUE SHIELD

Q. How many different types of Blue Shield protection are there under the Federal Employee Program?

A. There are two basic Blue Shield contracts—High Option ($300 surgical with in-hospital medical care which pays $15 first day, $10 second day, $4 per day through 10th, and $3 per day, 11th through 120th day.) Low Option ($200 surgical with in-hospital medical care $3 per day beginning the first day through the 30th day.) Supplemental benefits are available in addition to the basic. Charges not covered by basic benefits may be covered in part by supplemental benefits.

Q. What are the allowances for a normal delivery under the Federal Employee Program?

A. For a normal obstetrical delivery, they are as follows: Low Option pays $60. High Option pays $90.

Q. Does the Federal Employee Program cover routine newborn care?

A. No. However, benefits may be paid when the newborn care is *more than routine.* For example: Treatment of RH babies, premature infant needing specialized care, mongoloid and hydrocephalic babies, and those with spinal bifida where active definitive treatment is required.

Q. Does the Federal Employee Program provide for emergency first aid?

A. The schedule provides certain benefits for an accidental injury within 72 hours of the injury where no other basic surgical benefit is payable.

Q. How much coverage is available for in-hospital medical days for nervous and mental conditions under the Federal Employee Program?

A. Allowances are for 30 days under the High Option and 10 days under the Low Option. These are the maximum aggregate days paid during a consecutive 12-month period. (See answer to the first question for amount of daily allowance under both options.)

Q. What are the benefits for anesthesia service under the Federal Employee Program?

A. Under both High and Low Option, payment equals 20% of the schedule indemnity allowance paid for the surgical or maternity care involved. Minimum payments are $15 under the High Option and $10 under the Low Option. Anesthesia must be administered by a medical doctor other than the attending physician.

Q. Approximately how many people are covered by Blue Shield in Kentucky under the Federal Employee Program?

A. Around 50,000.

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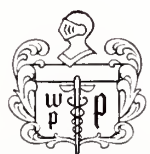

PUBLIC HEALTH PAGE

Laboratory Evaluation of the Fluorescence Inhibition Test For Toxoplasmosis*

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

RECENT reports in the literature indicate that toxoplasmosis may be much more prevalent than was previously suspected, and further interest in the clinical manifestations of toxoplasmosis has brought an increased number of requests to the Division of Laboratory Services, Kentucky State Department of Health, for laboratory tests to assist in the diagnosis of toxoplasmosis. The Division of Laboratory Services, although not providing diagnostic tests for toxoplasmosis directly, has been able to obtain through a reference laboratory the Sabin-Feldman Dye test on serum specimens from selected suspected cases.

Pilot Project

In an effort to develop more efficient laboratory support for the diagnosis of toxoplasmosis, the Division of Laboratory Services is now participating in a pilot project to evaluate the Fluorescence Inhibition (F.I.) test for toxoplasmosis. Seventeen state health department laboratories and the Laboratory Branch of the Communicable Disease Center, U. S. Public Health Service, are participating in this evaluation.

Serum specimens for the evaluation study will be selected from those submitted for the Sabin-Feldman Dye test to the state health department laboratories participating in the study. These state laboratories will split samples, perform the F.I. test in their laboratory, and submit an aliquot to the Communicable Disease Center Laboratories. The Toxoplasma Laboratory, Mycology and Parasitology Section, Communicable Disease Center will run both the Dye test and F. I. test on the aliquot submitted to them and the results of the Dye test will be reported through the state health department laboratories to the physician submitting the specimen. After a suitable number of specimens have been evaluated, an analysis will be made of the comparative results of the F.I. and Dye test. If the analysis indicates that the F.I. test has practical application in a state health department laboratory, the Division of Laboratory Services expects to provide this test to the physicians of Kentucky.

Fluorescent Antibody Test

The fluorescent antibody test is based on the principle that a specific antisera labelled with fluorescein isothiocyanate will attach itself to its specific homologous antigen, and that the resulting antigen-antibody complex will show fluorescence when viewed with a microscope having a suitable ultra-violet light source. The fluorescence inhibition test as used in this project is a modification of this direct staining technique in which the presence of specific antibodies in an unknown serum specimen may be detected. Preliminary reports indicate that this test is capable of providing a rapid means of detecting antibodies against the Toxoplasma organism, and that it may offer several advantages over other serological tests for toxoplasmosis.

Physicians desiring to submit specimens for the evaluation study may do so by submitting 6-8 cc. of clotted blood to the Division of Laboratory Services, Kentucky State Department of Health. Only those specimens from suspected congenital cases and their mothers, or from eye lesion cases in which toxoplasmosis is suspected, may be accepted. Each specimen must be accompanied by adequate clinical information, and special submission forms are available from the Division of Laboratory Services for this purpose.

**This article was prepared by B. F. Brown, M.D., M.P.H., director, Division of Laboratory Services, Kentucky State Department of Health, Frankfort, Ky.*

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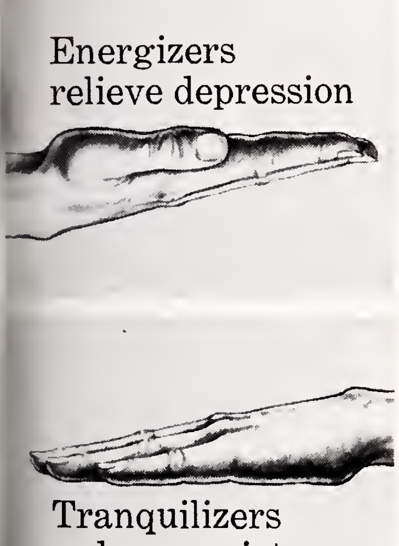

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WASHINGTON NEWS DIGEST

WASHINGTON, D. C.—The American Medical Association urged changes in the federal income tax law that would increase allowable deductions for medical expenses of older persons. Percy E. Hopkins, M. D., Chicago, chairman of the AMA Board of Trustees, and Francis C. Coleman, M. D., Des Moines, Iowa, chairman of the AMA Council on Legislative Activities, outlined the Association's position before the House Ways and Means Committee.

Most of the amendments proposed by the AMA involve changes in the Internal Revenue Code affecting those 65 and over and persons contributing to their support. These changes include: Permission for a taxpayer to deduct, without regard to the amount of support contributed, any medical expense paid for an aged dependent. Reduction of the income tax liability of lower income persons among the aged who have large medical expenses. Permission for aged taxpayers to receive full tax benefit for medical expenses by use of the carry-forward and carry-back method, just as businesses are presently permitted to offset losses in one year against profits in another year. Removal of the 1% floor on drugs and medicines for taxpayers 65 and older.

The AMA recommended the tax law changes to the House Committee shortly after President Kennedy had sent to Congress a special message asking again for Congressional approval of his plan that would put limited health care of the aged under Social Security. The AMA reiterated its determined opposition to such legislation.

The Administration's new health care plan generally was similar to the King-Anderson bill which the Senate rejected last year. The major change would extend the health coverage to the 2,500,000 older persons not covered by Social Security. A variable hospitalization benefit program would be available to all aged Social Security beneficiaries with costs paid from funds provided by an increase in Social Security taxes. Coverage for those not participating in Social Security programs would be paid from general tax revenues. Beneficiaries would have the option of selecting from three coverage plans—45 days of hospitalization with no deductible; 90 days with a maximum $90 deductible; or 180 days with the insured paying a deductible equal to 2½ days of average hospital costs. Home nursing facilities, out-patient diagnostic services and up to 240 home health-care visits a year by community visiting nurses and physical therapists also would be provided.

Administration officials estimated the cost would be $7,000,000,000 for the first five years. Insurance officials predicted the cost would be substantially higher.

Under the proposal, Social Security taxes for both employers and employees, would be increased ¼ of 1%. The Social Security tax for the self-employed would be hiked 2/5 of 1%. President Kennedy also requested that the annual earnings base from which Social Security taxes are collected be raised to $5,200 from the present $4,800. The plan would start Jan. 1, 1965, and require an extra $27.50 contribution yearly from both the employee and employer where the employee makes $5,200 or more. Maximum added cost to the self-employed would be $42.40 a year.

George M. Fister, M. D., president of the AMA, said the Administration's new plan "proposes a government-controlled program which would force increased taxes on wage earners and employers to buy limited hospitalization, nursing home and nursing care for millions of people over 65 who are financially able to take care of themselves.

"The use of tax funds to provide benefits to an entire population group regardless of need, the wealthy and well-to-do included, is just as unwise and economically unsound today as it was last year and the year before that," Dr. Fister said.

"The American Medical Association believes in helping those who need help, using tax funds where they may be required. We believe citizens of whatever age who are able to take care of themselves should not become a burden on the taxpayers. We believe the vast majority of Americans share our view."

* * * * * *

The AMA endorsed the Kennedy Administration's mental health and mental retardation program. Testifying before the Senate Committee on Labor and Public Welfare, Leo H. Bartemeier, M.D., former chairman of the AMA's Council on Mental Health and medical director of Seton Psychiatric Institute, Baltimore, said:

"We believe these measures should be implemented in such a way as to guarantee every American the very best in medical care and treatment, and we stand ready to help achieve this standard. There is little doubt that these bills are of the utmost importance in our common goal of improving the nation's mental health profile."

The AMA particularly supported the basic approach to the Administration bills, namely that the mental health program should concentrate on development of community facilities for care of patients at a local level.

"The American Medical Association heartily approved of the concern shown by the President of the United States and by this Committee over what we consider to be America's most pressing and complex health problem," Charles L. Hudson, M.D., Cleveland, Ohio, a member of the AMA Board of Trustees, said.

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J. THOMAS GIANNINI, 1169 Eastern Parkway, Louisville (Alternate) Jan. 1, 1963-Dec. 31, 1964
J. VERNON PACE, 333 Broadway, Paducah .... Jan. 1, 1962-Dec. 31, 1963
JOHN C. QUERTERMOUS, Murray (Alternate) .... Jan. 1, 1962-Dec. 31, 1963
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THE JOURNAL

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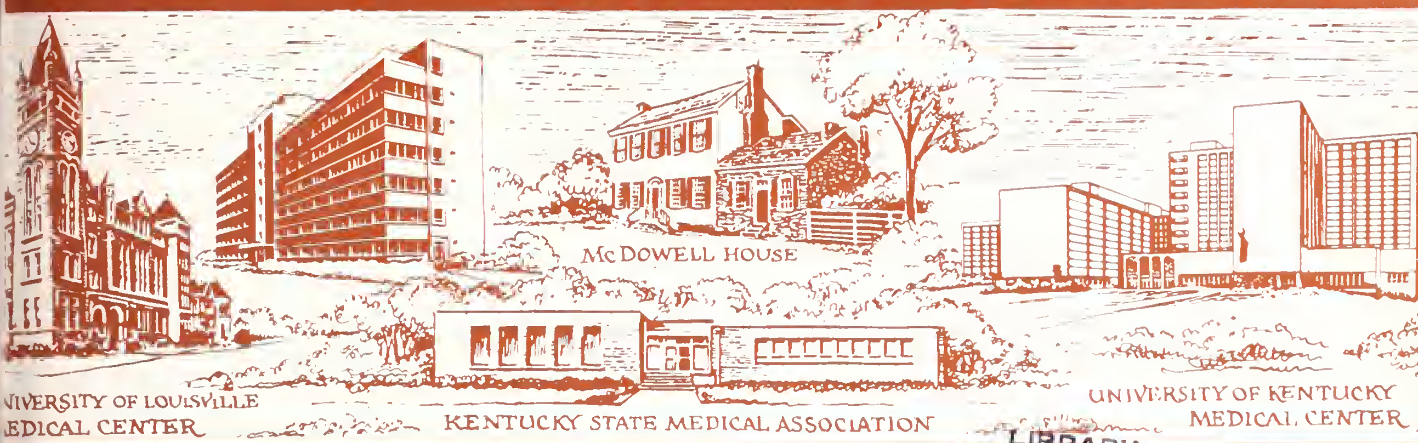

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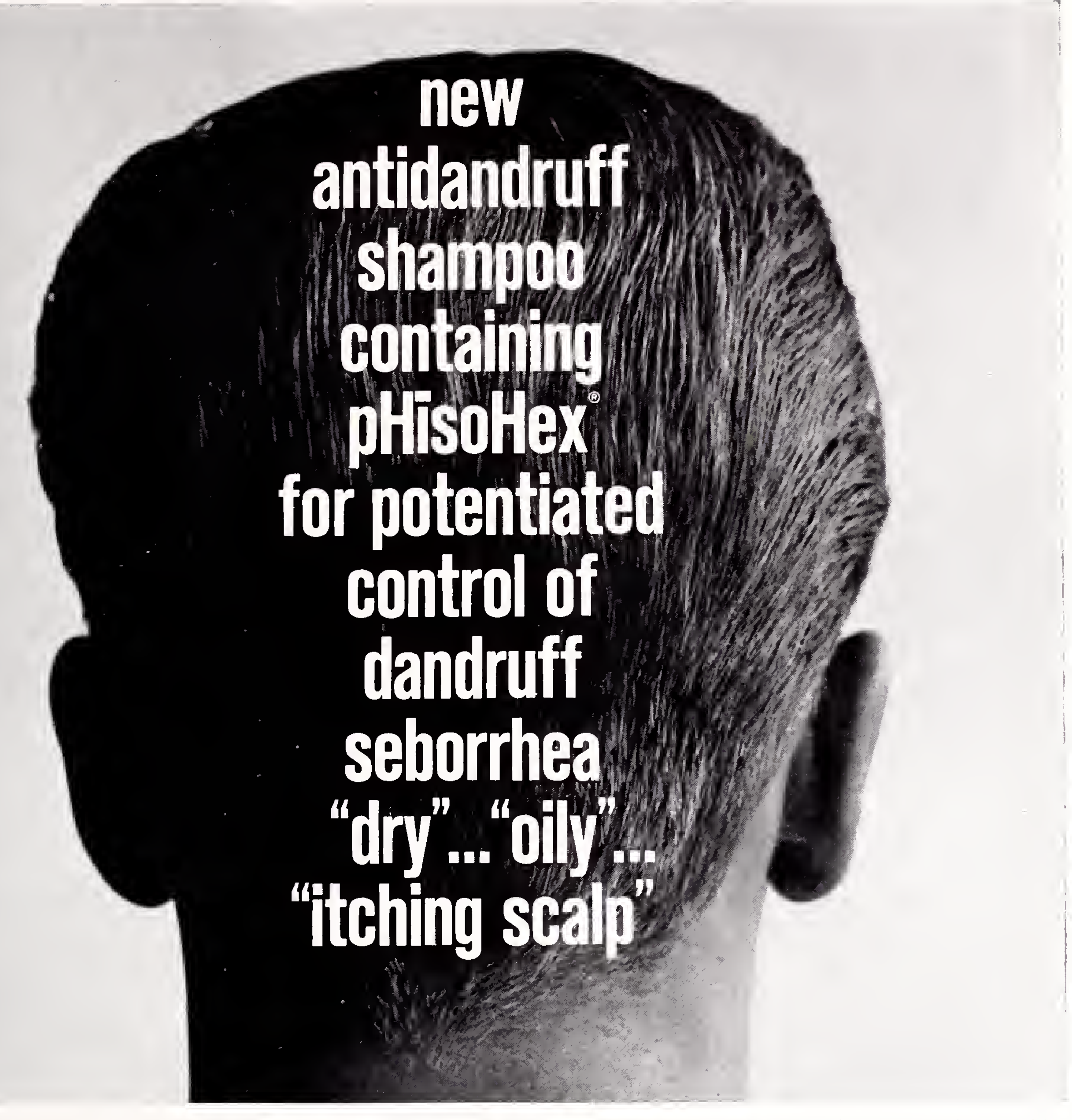
pHisoDan*



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MESSAGE FROM THE PRESIDENT

KEMPAC

KENTUCKY Educational Medical Political Action Committee is a non-partisan voluntary group of physicians, their wives and friends. KEMPAC was formed to let the public know that the medical profession is vitally interested in preserving the private enterprise system. Our country was founded by men dedicated to protect the individual from government interference, dictation and rule.

The laws of this country are made by our representatives in Congress. Therefore, if we want laws favorable to the individual, we must select candidates who think and believe in the voluntary and not the compulsory way of life. We must select and elect men who will vote for private industry and not for socialism.

The physician and his family can and should become active in the party of their choice. They must take a part in the precinct activity of that party.

The second important field of our political service is in supporting our candidate financially. When we give of our resources, we are more vitally interested in how the elected candidate performs when he is in the legislative body.

The Board of Directors of KEMPAC is made up of one physician from every Congressional district. Each has an alternate who attends meetings and is active in the money-raising campaign. It is earnestly hoped that every doctor and his wife will contribute at least $20 each in this most important task. Any contribution for a political cause is not deductible; that is the reason organized medicine cannot enter into political activity. We must work for the way of life we believe in.

How is the money used? It is contributed to help elect men to Congress who have promised to support private enterprise—men who believe integrity and work are more desirable than a "care-free" life on a dole from our government.

For many years socialization of our country has been progressing relentlessly with government going into one field after another in cooperation with, then in competition with private enterprise. Medical care to the aged is the present wedge of attack. The only way this process can be stopped is on the precinct level by electing men to represent us who believe that our personal enterprises system is better for Americans than a government-controlled system. For the ultimate success of the above objectives, we must work in the political party of our choice in helping to select and elect men who have statesman like qualifications.

We must be organized outside our medical associations to accomplish the education necessary to be effective. This can be done through KEMPAC. I hope every KSMA member and Woman's Auxiliary member will join and become active in order to preserve good medical care for all the people.

David M. Cox

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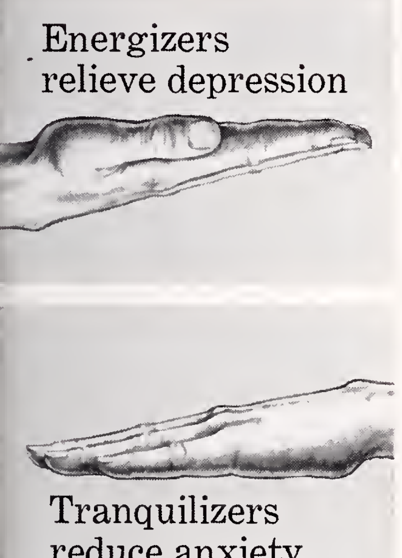

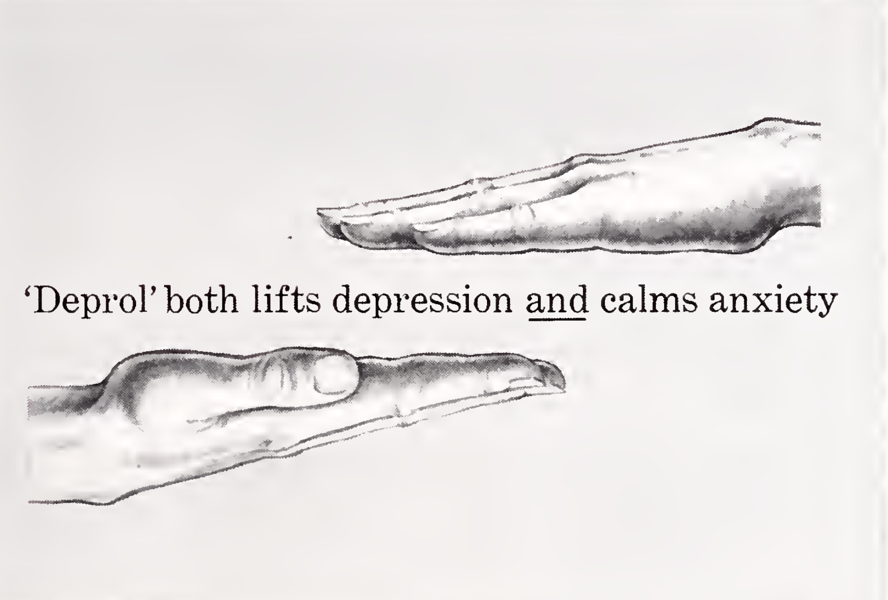

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THE INSURANCE PAGE

The Real Losers

There are many ways in which physicians can be guilty (intentionally or otherwise) of participating in abuses of voluntary health insurance and prepayment.

Such unwholesome practices as deliberate misrepresentation of facts on insurance claim forms; or the performance of unnecessary surgical and medical procedures in order to collect the insurance fees are mentioned only to point out that such acts are never performed by ethical members of the profession, who constitute the vast majority of the profession.

Perhaps less dishonest in intent, but certainly no more justifiable in theory, is the sometime practice of increasing one's fees above the usual and customary level, to those patients who have insurance coverage, on the assumption that such protection renders the insured more capable of paying the higher fee than are other patients of similar income level. Such differentiation defeats entirely the purpose of using a portion of one's income to purchase the insurance protection. Here, too, we would like to believe that only a small percentage of physicians could be found guilty.

The abuses which offer the greatest peril to the solvency of the voluntary prepayment plans are those of which an appreciable percentage of physicians may at times be guilty, and for which the physician may have only sincere motivation.

Such practices as unnecessary hospitalization; undue prolongation of hospital stay; the ordering of excessive laboratory and other diagnostic measures which have no more than academic relationship to the clinical management of the case; these are but a few examples of how any of us may inadvertently add to the rising cost of medical care.

Who are the real losers from these and other abuses of the prepayment funds?

The answer to this question is simple, if we remember one basic fact about all voluntary health insurance and prepayment plans.

Health insurance does not create wealth. It merely uses pooled funds, which have been created through the participation of a large number of people, to protect the small percentage of these people who may chance to experience illness, against the larger costs of their illnesses.

The immediate losers from misuse and abuses of these funds, may appear to be the insurance companies. The end result of these abuses, however, will be to necessitate an increase in the premium rates, and the ultimate losers will be the purchasers of the insurance protection—in other words, the public.

What could be the effect of such rising costs, as far as the medical profession is concerned?

First of all, (justly or unjustly) we will receive a large share of the blame for the increased costs of health care.

The proponents of socialized medicine in this country would like nothing better than to see a rising tide of resentment against our profession, due to the high costs of medical care.

The eventual result to our profession could be a loss of our free enterprise system of practice; if public demand should ever lead to a replacement of voluntary health insurance by a system of compulsory "insurance" under governmental control.

Physicians, no less than the rest of the public, have a stake in the continuing success of the voluntary prepayment plans. We must assume our share of responsibility in helping to keep these plans solvent and effective.

W. VINSON PIERCE, M.D.

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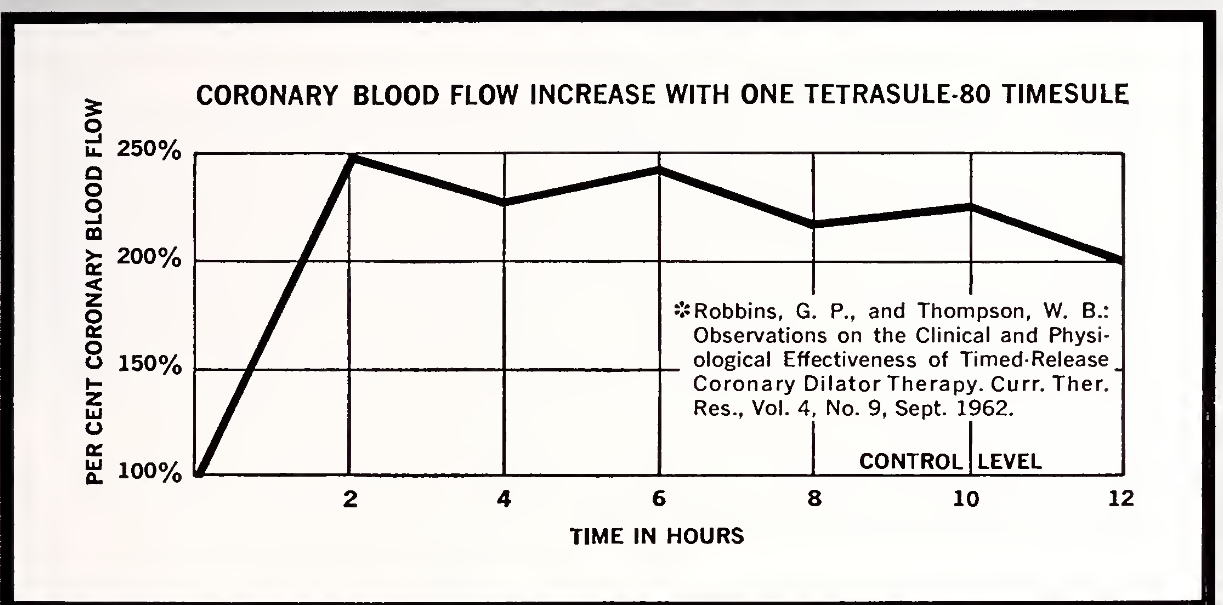

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2. Fluoride Compounds, Accepted Dental Remedies, 27th Ed.:139, 1962.

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PUBLIC HEALTH PAGE

The Zoonoses*

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health, Commonwealth of Kentucky

THE relationship between the health of man and that of lower animals becomes more and more significant as new disease entities are discovered and old ones further explored. Newly recognized human-animal disease relationships are being reported with increasing frequency. As a result the phrase, "in man and animals," is becoming commonplace in the titles of medical and research papers dealing with a wide variety of diseases. Farm animals, pets, and wildlife species are all capable of serving as reservoirs for a host of diseases to which man is susceptible. For this reason today's practicing physician must be ever mindful of the possibility that his patient's illness is perhaps the result of direct or indirect transmission of a disease agent from a reservoir in lower animal species.

Presently the World Health Organization Expert Committee on Zoonoses lists more than 100 infectious diseases which are common to animals and man. The list of recognized zoonoses, which includes diseases of viral, rickettsial, bacterial, mycotic, and parasitic etiologies, continues to grow. Of course not all of the reconized zoonoses are endemic to this part of that world. It is enlightening to note however that no less than 80 different ones have been diagnosed and reported in the United States.

Admittedly many of these infections are extremely rare and do not, on the basis of numbers alone, constitute a serious public health problem. Others such as salmonellosis, ornithosis (psittacosis), rabies, rocky mountain spotted fever, trichinosis, Q fever, tularemia, leptospirosis, the arthropod-borne viral encephalitides, brucellosis, cat scratch fever, the dermatomycoses, etc., are more commonly encountered and sometimes lend themselves to community-wide control programs. Further research will undoubtedly indentify other as yet undiscovered human-animal disease relationships. For example, one might speculate that studies on lower animal tumors may not only demonstrate environmental factors which influence tumor development in the tissues of both man and animals, but may in the future identify animal species which can serve as reservoirs or vectors of human tumor viruses.

This article was prepared by J. W. Skaggs, D.V.M., M.P.H., principal veterinarian, Division of Medical Services, Kentucky State Department of Health, Frankfort, Ky.

It is well to remember that the incidence of human illness attributed to the zoonoses generally reflects the activity of the infectious agent in its extrahuman reservoir. Often the adaptation of the agent to its primary host is so advanced that no clinical signs of disease are manifest. For example, sheep and cattle infected with the rickettsia which causes Q fever exhibit no detectible signs; birds infected with Saint Louis encephalitis virus suffer no apparent illness, etc. Consequently, wiping out overt disease is often not the primary consideration in controlling the zoonoses. It is usually more important to fully understand the epidemiology of the disease in question, including knowledge of the biologic and ecologic factors which affect the agent and its reservoir hosts, and then intelligently deal as best we can with what are often ineradicable mammalian, bird, or arthropod sources of infection.

Generalities About Zoonoses

Although each disease must be considered individually, certain further generalities about the zoonoses should be expressed. 1.) Like almost all other infectious diseases the overall incidence of the zoonoses appears to be decreasing. 2. Occupational exposures play an important role in the distribution of many of the zoonoses. (Farmers, veterinarians, packing house workers, and others who have repeated and intimate contacts with lower animals often head the victim list of particular zoonotic diseases.) 3.) Man generally acts as a secondary, incidental or "dead-end host," and tends not to transmit the zoonotic agent to his human or animal contacts. Therefore he is not an essential element in the natural perpetuation of the disease.

In our modern society man continues to have repeated opportunity to contact lower animals. There are presently more than 600,000,000 head of domestic livestock (cattle, hogs, sheep, horses and mules, chickens, turkeys and ducks) on farms in the United States. In addition 55.6% of all families in the U. S. have a pet of some kind and the sport of hunting has become progressively more popular. With such facts in mind one can readily see that human exposure to animal-borne disease can occur in any segment of our society. Recognition of the zoonoses is a challenge to the modern medical practitioner; reporting them to the proper control authority is his obligation.

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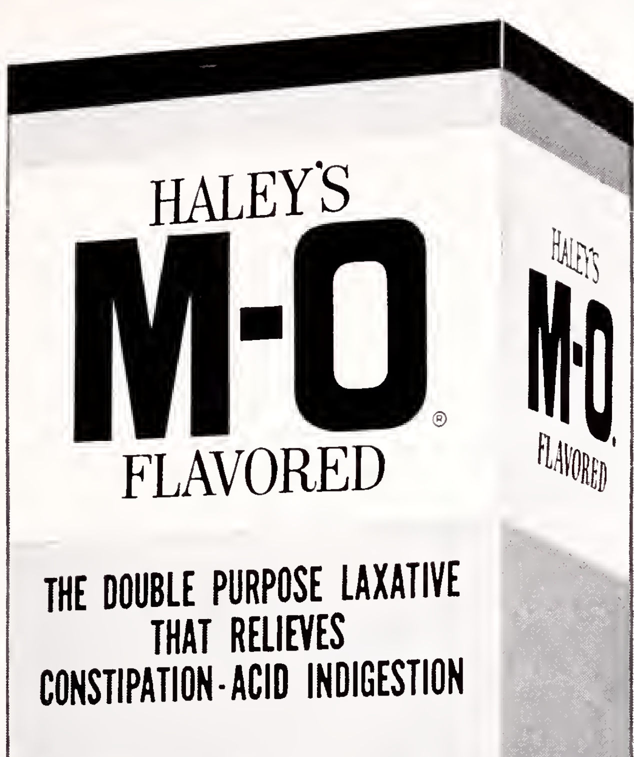

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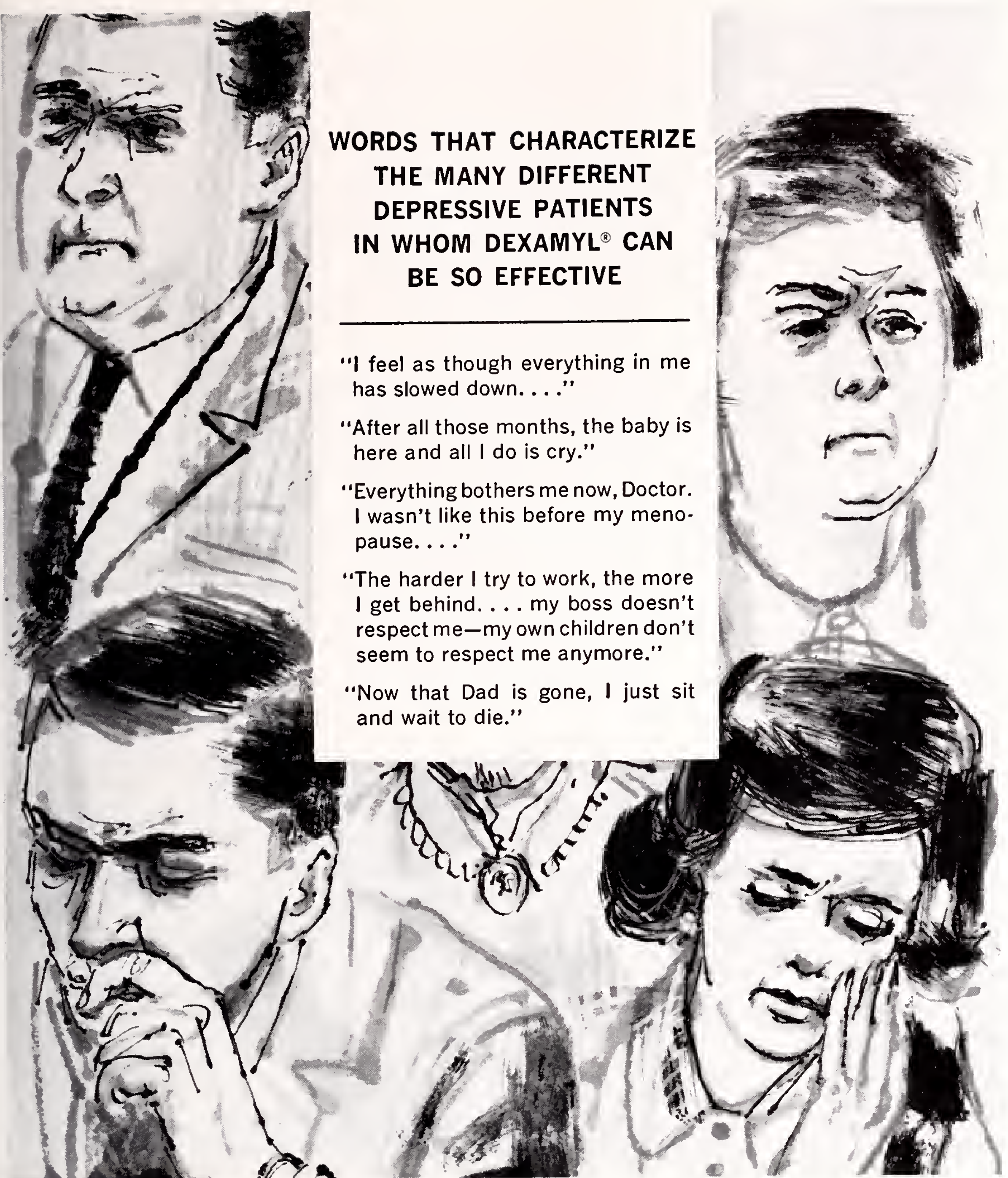

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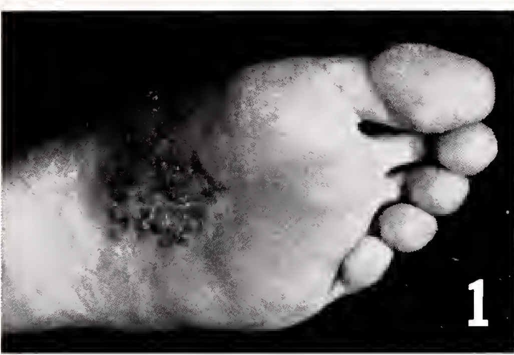
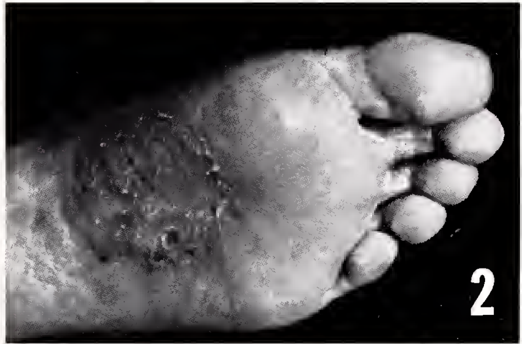
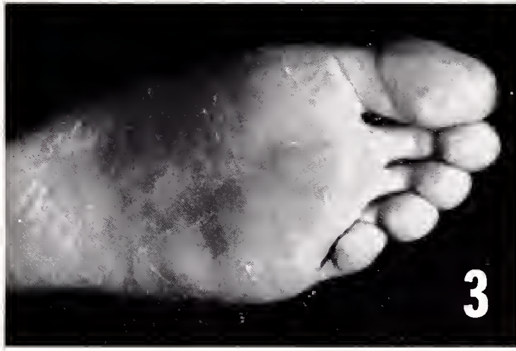
The patient was started on 0.5 gm. FULVICIN-U/F (griseofulvin, *ultra-fine*) daily. Three weeks later there was distinct improvement with only mild erythema and scaling present. After one additional week, therapy was discontinued and a second culture was negative. The patient was last seen on December 24, approximately three weeks after termination of therapy. At this time the skin was entirely normal in appearance.



1 Plantar tinea pedis before therapy.



2 After two weeks of therapy.



3 Six weeks later, skin essentially normal (two weeks after termination of therapy).

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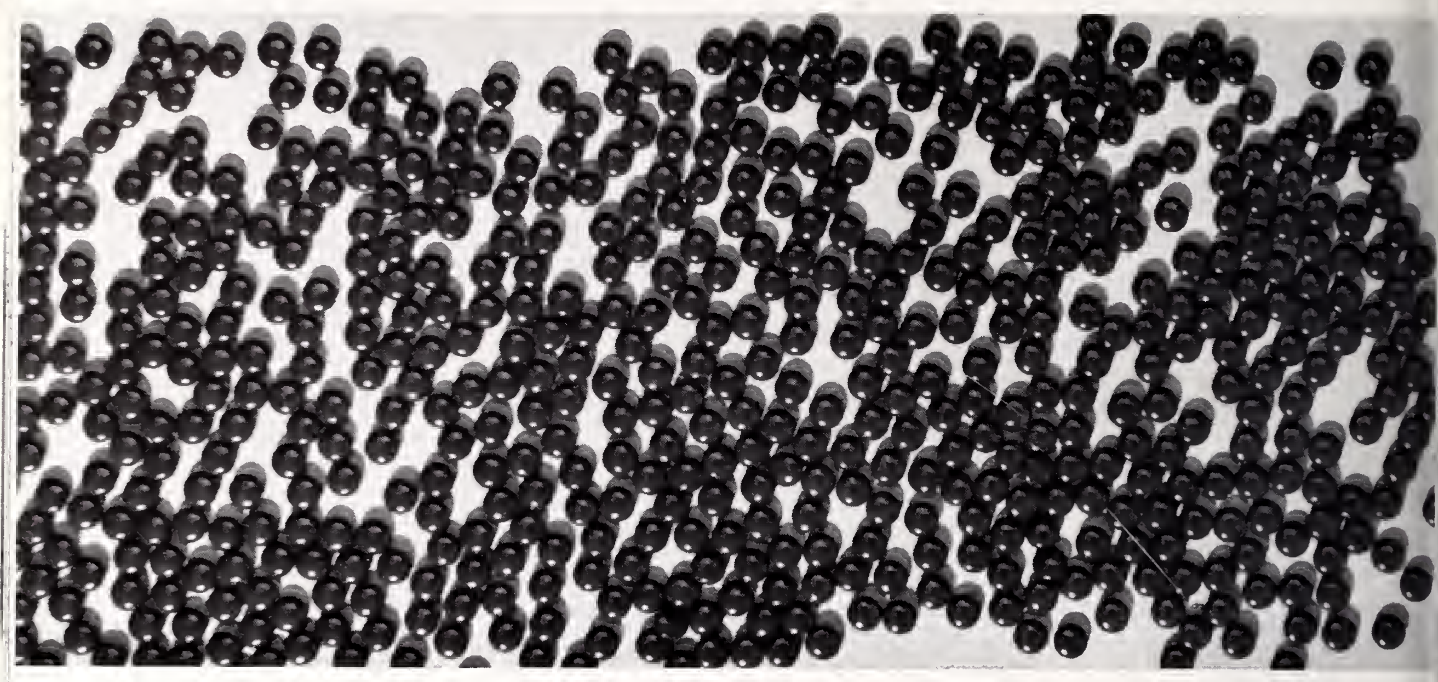

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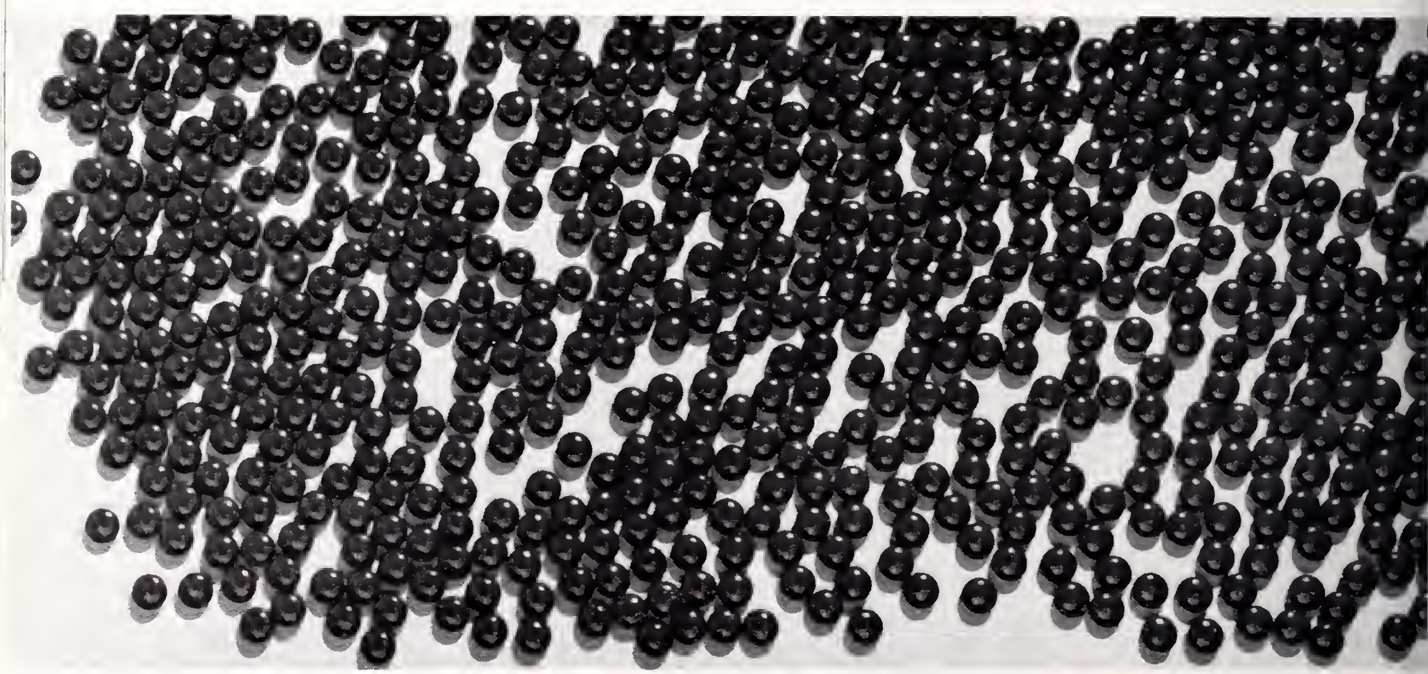

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Group Psychotherapy as a Means of Approaching Homosexual Behavior Among Hospitalized Psychiatric Patients*

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Lexington, Ky.

Homosexual behavior shown by chronic schizophrenic men in a mental hospital was approached through group therapeutic techniques. Improvement on a social level was found, without evidence of underlying personality changes of a more permanent type.

HOMOSEXUAL behavior frequently becomes more evident when members of the same sex live together in close knit groups for long periods. In the mental hospital where there is a separation of the sexes or where only one sex is hospitalized homosexual drives often become intensified. Such drives, being socially unacceptable, become disruptive factors for both patients and staff, interfering with efforts to establish a therapeutic milieu.

This report concerns our experiences with a group of chronically ill hospitalized male psychiatric patients, all showing varying degrees of homosexual behavior. Our ward was an open one consisting of 154 beds. Men on this ward all showed similar levels of social adjustment. Homogeneous grouping of patients formed to handle particular problems are not unique in psychiatric practice. Groups of homosexuals have been formed in the past, apparently almost exclusively in detention institutions or in hospitals where they have been sent because of their homosexual practices.

Hadden[2] reported promising results in his private practice with two groups of homosexuals, one consisting of three and another of seven males. Cabeen and Coleman[1], working in a state hospital with sex offenders, used group therapy as a part of a total milieu approach. However, their groups consisted of relatively few homosexuals.

So far as we know, there has been no reported attempt to treat the problem as one of ward management. This problem is unlike most for which groups are specifically oriented. Homosexual behavior and practices on the part of a few not only affected the many patients not involved, but the ward personnel reacted to this behavior in an emotional fashion. Reports of homosexual behavior produced considerable pressure in the ward staff meetings for some type of repressive measures or for transfer of the offenders from the ward. In describing such incidents we found that personnel tended to make their reports rather vague and at times contradictory.

Our first approach to this problem was to search for consensual and behavioral definitions.

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This served to disqualify some "suspicious" behavior, as patting each other on the shoulder or other casual physical contact. We did come to an agreement to include as homosexual all behavior which was overtly seductive, and of course included incidents of direct genital contact.

Rather than to continue either to ignore the problem or to use more repressive measures, an alternative procedure was presented to the staff. It was agreed to carry out the following steps. For a period of three weeks names of all men participating in homosexual activities, according to our criteria, were listed by the nurse. The 13 patients identified in this way were then seen as a group. They were informed that it had come to the attention of the staff that they had been involved in relationships with other men and they were invited to meet as a group to discuss this situation. It was emphasized that these relationships constituted a breach of ward policy, but any mention of terms such as "homosexual" was carefully avoided. Ten of the 13 indicated their interest in continuing to meet as a group, but two of them dropped out after nine sessions. The eight remaining patients continued to attend the group meetings for a six-month period.

Meetings were held twice weekly, each session being one hour in length. The ward psychologist and the ward psychiatrist alternated in leading the discussion, the other acting as the observer, taking notes unobtrusively. The members of the group quickly adjusted to this procedure. All members of the group carried a psychiatric diagnosis of Schizophrenic Reaction, with predominantly paranoid and hebephrenic features of long duration. Their ages ranged from 27 to 44. Several had been married and had children, although none had lived with their wives for several years before hospitalization.

Members of The Group

Mr. K, the eldest member of the group, but appearing much older, was a 44-year-old, unmarried laborer who had a stormy past including threatening behavior toward strangers and complaints of being followed by the FBI. At the time of the group meetings he had been hospitalized seven years and was apathetic about his situation and mildly suspicious of any efforts made on his behalf.

Mr. E, aged 41, was a flamboyant figure in the group who was outgoing, physically obese, and shared the dominating role with another member. He had been in the hospital one year less than Mr. K and was both hypertensive and schizophrenic. He was married, with children, but had been separated several years.

Mr. C was more intelligent than the other members, more verbal in his deliberate fashion, and rendered support to Mr. E. He was 36, hospitalized nine years, and divorced, with one son. This patient was in stable remission and viewed his hospitalization as preferable to living outside.

Mr. H was a 38-year-old divorced auto mechanic who had been in the hospital only two years, although his history showed that he had been ill since 1941. A very noncommittal and taciturn sort of man, he was considered to be chronically but mildly ill. There had been some improvement and he was essentially asymptomatic. On one trial visit he had taken up residence with some homosexuals and had, at the same time, threatened the orphanage attendants who had custody of his one child.

Mr. M soon was the *persona non grata* of the group in that his participation was not completely accepted by the others. He was 27 years of age, unmarried, and highly anxious in the group. He had been in the hospital five years and had been offered a variety of rehabilitative opportunities without avail. He was a tall man who appeared, along with Mr. N, younger than his stated age and also sexually much less matured and sophisticated.

Mr. S was the most perceptive of any member and held most promise superficially. A man of 36 years of age, unmarried, with a skilled vocation, he was frequently droll in his remarks, but appeared to lack the motivation to reverse the chronicity that characterized him.

Mr. T was of dull intelligence, 39 years of age, single, and had been hospitalized three years. He was a farmer, was somewhat effeminate in his mannerisms, and found most comfort in the role of voicing agreement to anything that was said.

The most obviously effeminate in his behavior was Mr. N who was 39 years of age, single, and quite rotund. His smiling naivete tended to separate him from the other members, and his participation was often prompted by the leaders, or by Mr. C. His comments

were many times unrelated to the topic, and the hebephrenic features of his affect were clearly defined.

Group Interaction

It was soon apparent that the cautiousness of the leaders against typing the group as a homosexual one was unnecessary: Mr. C's pronouncement that "us queers are now getting together" left little room for doubt. The reactions to this statement and the succeeding focus upon homosexuality in its many facets resulted in interesting and varied reactions. Mr. M was overtly upset and finally expressed the fear that association with the group would make him homosexual, after an initial disavowal of knowing anything about it; Mr. C and Mr. E vied for group attention in their relating of various exploits and academic knowledge of the topic; Mr. H and Mr. K distanced themselves by claiming an immunity; Mr. N and Mr. T tended to moralize or pose ignorance of the topic; Mr. S reduced homosexuality to a physiological anomaly and objectively appraised it as such.

An analysis of the recorded interaction indicates that there was an initial period of search for causes. Sex was vaguely defined and homosexuality was linked to being oversexed, a glandular disturbance, or heredity. The leaders were perceived as specialists, a role which diminished as the interpretation changed from a physical to an interpersonal one.

Mr. N, who had considerable difficulty in accepting the problem area, brought up a family problem early in the sessions, which was met with little interest in the group. Mr. C, on the other hand, soon gave vent to negative feelings toward women and defended bachelorhood. A note of despair was shown in his statements beginning with the eighth session at which time he acknowledged that homosexuals who were trying to repress their desires were not permitted to do so by the group of non-homosexual acquaintances who knew of their past and who persisted in labeling them. One reason given for this was that most men felt that sex was power and they belittled the homosexual because he failed to exercise this power over women.

Discussing occasions of being approached by homosexuals preceded the turning to early experiences in this area. Early homosexual experiences were denied by most members of the group, and those who denied them appeared to enjoy a vicarious pleasure by listening to those who mentioned them in some detail. Even when discussing a hospital-wide known homosexual personality, he was carefully placed on a ward where he had been "locked up."

Other subjects more readily discussed were the hostility the group members felt was directed toward them as mental patients and the lack of understanding shown to them. Both Mr. C and Mr. E had much to say here, and other members of the group passively agreed with them. A question of being labeled as a homosexual by participating in the group was frequently raised by Mr. M who always denied any participation in homosexual activities.

After three months of regular meetings the group seemed less interested in homosexuality as a topic. The purpose of the formation of the group was reviewed, and the leaders made efforts to involve the silent members of the group in the discussion. They were especially hopeful that Mr. K and Mr. H might become more active participants. However, this was countered by repeated requests for more intellectual and theoretical knowledge, and most of the group except Mr. C and Mr. E ignored the suggestions that more individual participation might be helpful.

Difficulty in Remembering

The group seldom started a session on the topic of homosexuality, and members almost universally had difficulty remembering the content of previous sessions. Each session almost invariably started with a discussion of some activity or current event. Mr. S at one time did voice the feeling that homosexuality and adolescence seemed related. Mr. M continued to dwell on how he saw himself as a permanently injured person. Mr. C pointed out to him how his lack of self respect was related to similar feelings in homosexuals. Feelings of rejection by parents and society, caused primarily by mental illness, were some things Mr. H and Mr. S saw as a part of the general hostility and rejection homosexuals experienced.

After about four months Mr. C went on an unauthorized visit home but returned after several days. The group voted to accept him back. On his return, Mr. C described vividly

how he had been picked up and offered a ride by a man who made a homosexual proposal to him. Mr. C refused, even though—as he told it—he was let out of the car at a rather isolated crossroad. He attributed his refusal to his wish not to disappoint the group and to the fact that he had gained some understanding of his problems through the group. Other members discussed Mr. C's experience readily but continued reluctant to talk of their own problems. There was a consistent denial of any significant amount of homosexual activity ever being present on the ward. Several in the group at this time expressed their concern about impotence. This proved to be an easier topic for the group to discuss and might be one way to introduce the more difficult topic of homosexual behavior in future groups.

By the end of the fifth month Mr. M became more insistent that he be dropped from the group. His reasons were the same as those given earlier: Fear of acquiring the label "homosexual" or in some magical way of being made into a homosexual. We felt that he was defending himself against unconscious unacceptable impulses which he could handle only by denial, and we seriously considered his request.

Several other changes, however, finally led to the decision to draw the group experiment to a close. By this time Mr. C and Mr. E, both our most vocal members of the group, had left the hospital. Mr. C went to a half-way house and Mr. E returned home. There was a strong reluctance to continue the group meetings with homosexuality as the basic topic. The remaining group members wished to continue but to change the topic of the group to a discussion of more general problems. Because the group was small and there were other groups of a general nature in the hospital, we came to the conclusion that it would be wise to terminate the group. Accordingly, after a few sessions of review and recapitulation, the group was disbanded after six months.

Results and Discussion

Our evaluation is a subjective one but in general agrees with the report of Cabeen and Coleman. Their patients, hospitalized sex offenders, had weekly group meetings as a part of the treatment program. Using the Minnesota Multiphasic Personality Inventory to measure changes in personality functioning, they found several significant changes, all in the desired direction. After one year, patients showed less depression and less sexual deviation, as measured by these scales in the Inventory. The validity scale also showed less psychological defensiveness. All other scales showed no significant difference. Their conclusion was that major changes in personality structure were not found.

Social Improvement

Social improvement without too much change in basic underlying personality appears to have been the case in our group as well. The most important of all, we felt, was the fact that members of the ward staff reported that incidents of homosexual behavior were almost disappearing. None of the patients of our group were noted to be participating in these incidents at the time the group was disbanded. We also felt that the ward staff was able to approach incidents as they did appear with greater objectivity.

Our second major interest was what had happened to the individual group members. We felt we could detect several changes. The most striking was Mr. C's change in general attitude. While earlier he was very outspoken in saying he saw the hospital as a comfortable place to stay, he requested placement in a half-way house while the group was still going on and later held a job for several months. Mr. E about this time went home for a month's visit, which was extended to a trial visit. Mr. M continued to make many requests for changes in his assignment and medication. He continued unable to handle any type of activity for more than a week or two and later was transferred to a closed ward. While he no longer turned to homosexual behavior, we believe that his withdrawal and masturbation showed, if anything, an increase. Mr. K, the laborer, remains withdrawn and aloof. Mr. H and Mr. S continue chronically ill, although there are times when Mr. S shows some promise of gradual improvement. Mr. N, a naive, rotund, inappropriate individual, remains no better and no worse from his experiences. The same is true for Mr. T, our ex-farmer.

We were particularly interested in determining why these changes, especially on the ward behavior level, came about. We doubt that it was purely coincidental. It would seem that by

focusing on the problem through the formation of a group with therapeutic intent, we enabled staff personnel to approach the question of homosexual action more objectively. Meeting twice a week to discuss openly the development, ramifications and consequences of such behavior perhaps removed some of the emotional impact this type of sexually deviant behavior aroused. Also, even though most of our group did not come to accept the presence of such behavior or impulse within themselves, again objective open discussion tended to make homosexual behavior more like other deviant types of behavior. Familiar with the presence of more acceptable emotional tensions, sexually deviant behavior was less anxiety provoking both to themselves and to those around them. As such, the novelty and secondary gain of this regressive behavior was lost. The discussion may well have produced a type of substitutive phenomenon in which talking acted to reduce anxiety and tension and in effect became equivalent to the deed. We also believe that social forces helping to produce a conforming acceptable behavior were strengthened.

While the group did not like being identified as members of the "homosexual club," this was balanced by the special attention paid to them by the ward leaders. There seemed to be an increased identification with the purposes of the ward staff. From the first, there also seemed to be a tacit agreement among the group members not to participate in homosexual behavior among themselves. Although never verbalized, each seemed to derive support from membership in the group in this respect. Replacing the vague misinformation with a search for understanding was reassuring and gave added strength to the reduction of homosexual activity.

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Steroids in the Treatment of Dermatoses*

Lawrence C. Goldberg, M.D.**
Cincinnati, Ohio

The proper use of corticosteroids improves the treatment of dermatoses. The endurance and reliability of these drugs, used locally, orally, intravenously, intramuscularly or sublesionally, have been well tested and proved most valuable.

IT IS 12 years since Hench gave the medical profession a tool which has modified modern medical and dermatologic therapy. The corticosteroids have reduced the duration, discomfort and associated symptoms of many dermatoses, even though we cannot say they have cured any skin diseases. They probably have been used more than any other group of medicaments in dermatology today, and it is more than likely they are employed in dermatologic therapy more often, in larger dosage, and in more ways, than in any other specialty.

The discriminate use of the steroids, whether used topically, orally, intra or sublesionally or parenterally, is almost a necessity now. If the physician maintains a healthy regard for the fact that he is using a potent drug which, when given in proper dosage, will produce in the indicated case a result beneficial to the patient, then he need have few of the fears that are associated with steroid treatment. In general, if he considers the beneficial effects versus the side effects, there is really no absolute contraindication to the use of steroids in dermatologic therapy.

Local Application

Local use of the steroids created a furore in the early '50's. Now there is hardly a basic dermatologic preparation that has not been compounded with one or another of the analogues of cortisone. Regardless of which cortisone preparation is used and whether it is in creams, ointments, foams or sprays, there will be some beneficial local effect in appropriate cases. The various chemically related topical corticosteroids ranging from 1% hydrocortisone acetate to 0.01% Synalar® cream, are generally acceptable and available in equivalent therapeutic concentrations. There are probably more than 400 different commercial formulations and we have our choice of 10 different cortisone analogues.

Following a survey of American and foreign dermatologists, a report was published in the March 1962 issue of Current News in Dermatology indicating that the drug most often used for local therapy is the corticosteroid preparation. Two-thirds of those who answered the query, "What is your favorite local treatment?" stated, "Corticosteroid alone or in combination with other drugs."

The incorporation of the halogen fluorine into the chemical structure of a drug usually results in changes in the pharmacologic action. This has been done in the corticoid field, supposedly increasing the potency of the topical steroids. Though I have not compared the more recent fluorinated topical corticosteroids with some of the older preparations I accept the reports by Gray, Robinson, Scholtz, Goldman and Rostenberg regarding the therapeutic potency of these materials. The use of Synalar[2] cream and Saran wrap in the treatment of psoriasis, still leaves much to be desired, though it is of definite value in some cases. Local therapy should be used only when small areas are affected since the expense of the drug is too great if large areas of the skin are involved. Dermatoses of large areas can be better controlled by systemic steroids. It is well to remember that neomycin may cause localized sensitivity despite being compounded with steroids. This demonstrates that there is no such thing as an airtight solution to the problem of epidermal contact sensitivity. The local use of

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steroid medication by itself will not alleviate all skin diseases. Older, conventional forms of dermatologic therapy must still be used. However, steroids serve as excellent adjunctive therapy, often reducing the duration and severity of the ailment.

Oral Use

Available today are 10 cortisone analogues that can be orally prescribed, although most of the present day use is confined to the newer ones. Cutaneous problems for which there has been or still is no specific treatment, can now at least be controlled. Many dermatoses have some allergic background and will respond to steroid, dosage not exceeding 8 to 12 mgs. per day. If the newer analogues are given in dosage exceeding 16 mgs. a day for longer than three weeks, one can definitely expect steroid complications, and in some cases this may occur on less dosage and in an even shorter period of time. The drug should be continued in decreasing dosage for at least 10 to 12 days after symptoms of the disease have disappeared, otherwise rebound reactions can be expected.

Oral treatment with steroids decreases the duration of many cutaneous disorders and often it increases the action of other drugs which previously might have been ineffectual in the treatment of the same disease. As a result the disorder becomes more responsive to some conventional older type of treatment. As an example, the duration of discomfort in dermatitis venenata caused by poison ivy has been cut from one-half to one-third the time necessary to heal the eruption and the effectiveness of local therapy has been improved.

A word about a few particular diseases; The drug of choice in treating psoriasis is Aristocort,® if steroids are to be chosen. About 60% of the patients will show a response within 6 to 10 days on correct dosage. If there is no response to 45 x 4 mg. tablets in 15 days, the drug should be discontinued. The steroids are of value in the treatment of herpes zoster but should be started in the first 72 hours of the disease. In my experience there is very little effect on post-herpetic pain. Alopecia areata and totalis will respond to 12 mgs. of the corticosteroid analogues daily but do not expect any dramatic results under 6 to 12 weeks of therapy. The drug must be continued in lesser dosage for a longer period of time after the hair regrows. If not, the alopecia will recur.

In dermatoses associated with superimposed infection, antibiotics should be used. Sarcoidosis, Hodgkin's disease, mycosis fungoides, leukemia cutis, systemic lupus erythematosus, dermatomyositis, scleroderma, pyoderma gangrenosum, pemphigus and various types of erythema multiforme have been and can be successfully treated with corticosteroids but large dosage must be used.

In modern pediatric dermatology the correct use of systemic and topical corticosteroids is essential. Often the drug is more useful, produces a better result, is less harmful, has a lower incidence of deleterious effects and a wider dosage leeway in children than in adults.

Parenteral Therapy

Local[1] injection of the newer analogues is occasionally used in dermatology. At present the one that appears to be the most promising is Aristocort diacetate containing 25 mgs. of the drug per cc. No more than 12.5 mgs. per cc is necessary when injections are made intra or sublesionally and in some instances as little as 5 mg. will achieve good results in the indicated cases. Two or three injections at two-week intervals may often suffice in reducing and sometimes obliterating the miserable pruritus of a severe lichen simplex chronicus, the obnoxious appearance of a patch of psoriasis on an exposed area, or the disfiguring appearance of some lesions of chronic discoid lupus erythematosus.

Some of the side reactions noted in this type of treatment are pain and puffiness at the site of injection which may last for several hours. If the injection is too superficial, a slough may occur. Residual erythema, atrophy and local loss of tissue substance have been seen in about 5% of the patients. This is a reversible reaction although it may take several months to a year before the area again appears normal. Depigmentation may occur at the sites of injection and on occasion some observers have reported nitritoid reactions following injections, of both the immediate and delayed type. Even though the scope of this therapy is limited, some of the results are most gratifying to both the physician and the patient.

Parenteral therapy with corticosteroids em-

ploys both soluble and insoluble preparations. During the past 50 months, I have used all available intravenous steroid preparations and I have found Solu-Medrol®[5] the medication that best demonstrated dissociation of therapeutic benefit from undesirable side effects. It can be used despite the fact that patients had developed reactions to other types of corticosteroid therapy, and can be given in either the office, home or hospital. It has been given to patients with hypertension, congestive heart failure, peptic ulcer, diabetes, severe emphysema and arrested tuberculosis. These associated diseases were not aggravated by the drug. The age limit has ranged from a six-week-old infant to a 95-year-old adult.

Intravenously the necessary amount of corticosteroid can be delivered to the inflammatory areas in the shortest period of time with maximum benefit and the least number of side reactions. Rauschkolb and Rauschkolb[6] state that, 15 minutes after intravenous injection of hydrocortisone sodium succinate there was a 75% decline in concentration of the medication in the blood stream, and that after three hours, although there was a substantial reduction in the corticosteroid, it was still biologically significant. This disappearance presumably reflects the combined effect of degradation and excretion as well as a continued diffusion into the tissues. Hydrocortisone free alcohol was detected in the skin five minutes after intravenous injection of hydrocortisone sodium succinate. The rapidity with which the steroid appears in the blood following gastric intubation is noteworthy, but the levels are low in comparison with those following intravenous administration. It is further concluded that more than one-half the steroid in the skin, after intravenous injection, is present in the intra-cellular fluid or formed elements.

I mention this work because it was conceived as a result of our studies with Solu-Medrol. The need for local therapy with lotions, salves and wet dressings can be minimized, thus reducing the incidence of overtreatment dermatitis. There is no desire on my part to depreciate the use of oral steroid medication, but if large dosage of these drugs is required over a period of time, or a rapid response to treatment is demanded, then I strongly recommend the use of Solu-Medrol. I cannot promise you that all patients treated will have a favorable response to this adrenal steroid, but so far as I know, neither will any be incapacitated by the side effects of the medication. Now that I have had four years of experience with this preparation, I would consider practice without I. V. 6-methylprednisolone as taking me back to the horse and buggy days of medical practice. This drug has antiquated the use of intravenous ACTH and in a recent article by Witten[7] and Sulzberger on corticosteroids, they do not even mention the use of ACTH either intramuscularly or intravenously.

Repository forms of Medrol and Aristocort (the latter recently studied by A. Weiner) are also available, but in my opinion are best used in chronic rather than acute skin diseases. The dosage usually ranges from 40 to 80 mgs. intramuscularly. In a study of the effects of Depo-Medrol, Kleeman states[8], "if 200 mg. of Depo-Medrol is injected intramuscularly, as high as 50% of the material may be inactivated by muscle tissue or enzymes—that the rate of absorption seems to be less than 20 mgs. a day and often less than 10 mgs. a day." It is for this reason that I state that the use of repository steroids does not seem to be justifiable in the treatment of acute skin or other diseases.

Summary

The various methods of treating skin diseases with corticosteroids have been reviewed. The proper selection and administration of available corticosteroids will improve therapeutic efficiency in the treatment of dermatoses. The endurance and reliability of corticosteroids, whether applied locally, given orally, intravenously, intramuscularly, or sublesionally, have been well tested and proved most valuable.

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Radiological Changes in Pulmonary Emphysema*

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Roentgenographic evaluation of pulmonary emphysema with plain films, fluoroscopy and laminagraphy is discussed. Laminagraphy distinctly increases accuracy in the x-ray diagnosis of this disease and its use is strongly recommended.

TO MANY physicians pulmonary emphysema is not a sharply defined entity. The word "emphysema" is derived from Greek and means "an inflation," which in itself is rather nonspecific. It would appear proper to infer that pulmonary emphysema denotes inflation of the lungs, or in a pathological sense, an overinflation of the lungs. Physicians in general, excepting those specifically interested in this disease, often view pulmonary emphysema simply in the broad sense of overdistension of pulmonary parenchyma. The truth of the matter is that emphysema may take many forms resulting from many mechanisms. It is possible to have severe pulmonary emphysema without the lung volume being significantly increased.

General Description

Since classical emphysema is characterized by destruction of alveolar septa and obstruction to pulmonary ventilation, particularly its expiratory phase,[1] the disease does, indeed, present on x-ray examination as hyperlucent lungs with resulting secondary changes.[2] For reasons which are not well understood, only a portion of one or both lungs may be involved. On occasions huge bullae or blebs may be seen with the remainder of the lungs being relatively normal. These bullae appear as vesicles of varying size. They may be relatively small or may occupy almost all of an entire hemithorax. No blood vessels or interstitial tissue is seen traversing the bullae which are well circumscribed by a fine curving line of density which represents surrounding compressed pulmonary tissues. At times the remaining relatively normal lung may be so severely compressed as to be of little value to the individual as a respiratory organ. At other times large bullae may be present in a completely asymptomatic individual.

Pulmonary Tissue

In the usual situation emphysema involves all of the pulmonary tissue although certain portions may be damaged to a greater degree than others. Expiration is seriously impeded and the lungs become strikingly distended. Consequently, chest films show increased radiolucency with decreased interstitial markings. As would be expected, changes occur in the thorax, diaphragms and cardiac silhouette secondary to air-trapping and overdistension of the lung (Figures 1 and 2). In far advanced emphysema there is increase in the AP diameter of the thorax, the ribs attain a more horizontal position and the intercostal spaces are widened. The diaphragms are low and flat and the costophrenic angles are widened. The heart is relatively small due to the continuous Valsalva effect of unremitting pulmonary distension. The lateral film shows an increase in the size of the retrosternal radiolucent shadow. Frequently the retrocardiac radiolucency is enlarged.

Since there is obstruction to expiration, fluoroscopy and inspiration-expiration films show decreased motion of the leaves of the diaphragm on forced respiration (Figures 3 and 4). It should be noted that this manifestation does not differentiate emphysema from asthma since air-trapping and expiratory obstruction is present in both conditions.

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***From the Department of Radiology, University of Kentucky Medical Center, Lexington, Ky.*

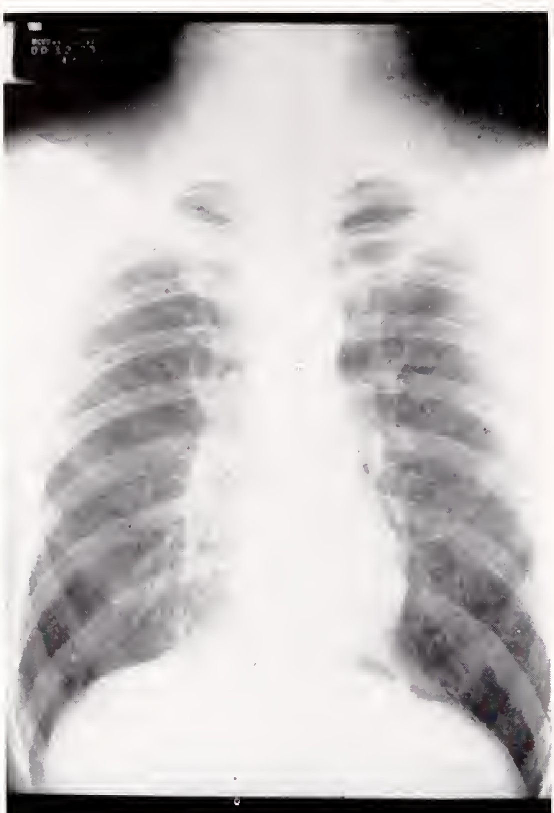

Figure 1: PA film of chest shows small heart, low diaphragm and widened interspaces.

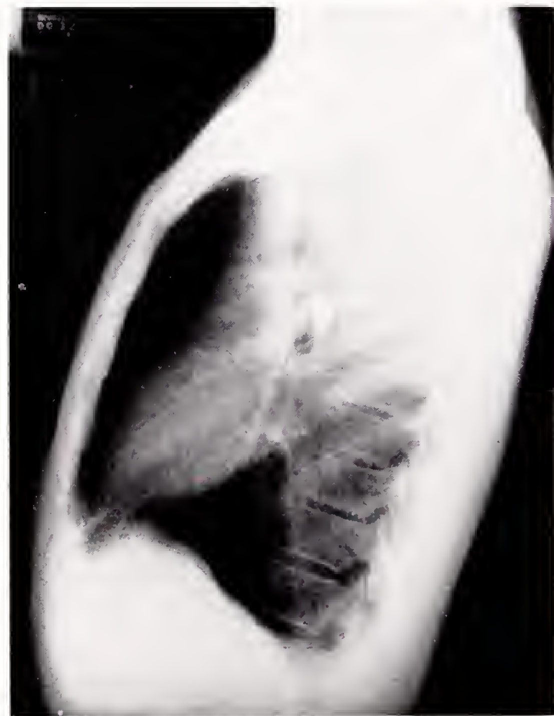

Figure 2: Lateral film of the chest reveals exaggerated retrosternal and retrocardiac radiolucencies. The changes demonstrated in Figures 1 and 2 are not so florid as those present in many cases of severe emphysema.

Effects of Emphysema

It has been shown pathologically that emphysema leads to compression, narrowing and destruction of many pulmonary arterial branches with resulting diminution in pulmonary blood flow. This is reflected on the chest film by a decrease in the number and size of the fourth and fifth order of pulmonary arteries as well as abnormally rapid tapering of these vessels. Although these changes may be appreciated on plain chest films, they are studied better by laminagraphy at or slightly behind the hila (Figures 5 and 6). The size and number of the pulmonary arterial branches are important x-ray differential points between pulmonary emphysema and spasmodic asthma since air-trapping is visible by x-ray in both processes. Uncomplicated spasmodic asthma is not attended by destruction of pulmonary tissue. The peripheral vasculature remains normal in this condition in contradistinction to the situation that obtains in emphysema.

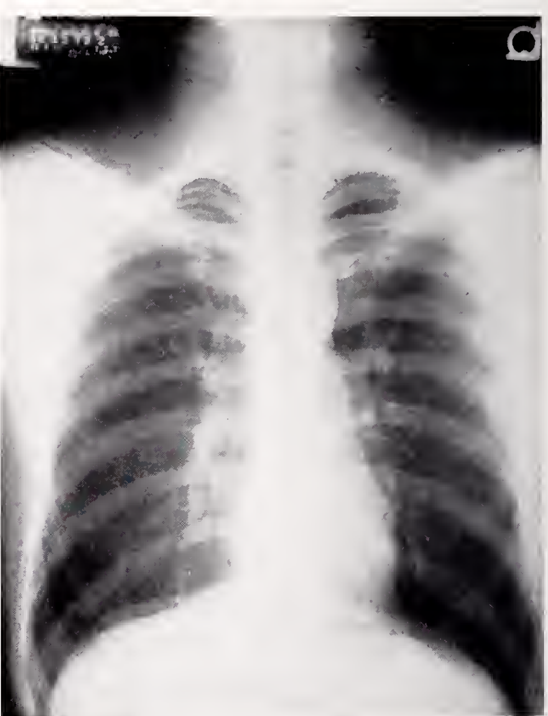

Figure 3: PA inspiration-expiration film in emphysema. There is marked restriction of diaphragmatic motion.

The destruction of pulmonary tissues with decrease in the pulmonary vascular bed of far advanced emphysema inevitably leads to increasing resistance to pulmonary blood flow. This eventually reflects itself in dilatation of

the main pulmonary arterial trunks. The resulting long continued severe pulmonary arterial hypertension finally causes enlargement and failure of the right ventricle with the full blown picture of cor pulmonale.

Bronchography is usually not required to diagnose pulmonary emphysema when clinical and radiologic findings are considered in concert. Nevertheless, this entity presents a rather characteristic bronchographic picture.[4] The bronchi are smaller than normal. Little alveolar filling is seen, causing the bronchial branches to present a "leafless tree" appearance. The bronchi are abnormally separated, with widening of the peripheral zone into which no branches can be seen to extend. There is bending and displacement of bronchi around enlarged, dilated emphysematous blebs. Opaque medium does not enter the bullae or blebs.

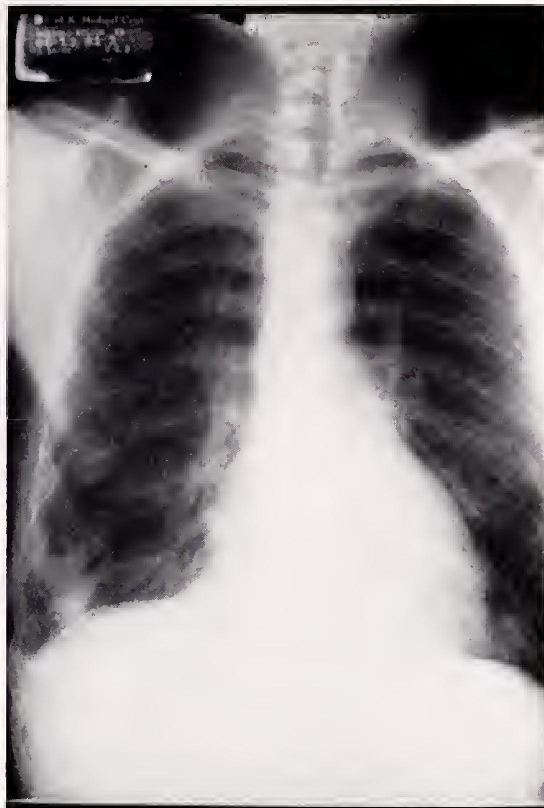

Figure 4: PA inspiration-expiration film in patient with a septic pulmonary embolus. Note approximately normal diaphragmatic excursion.

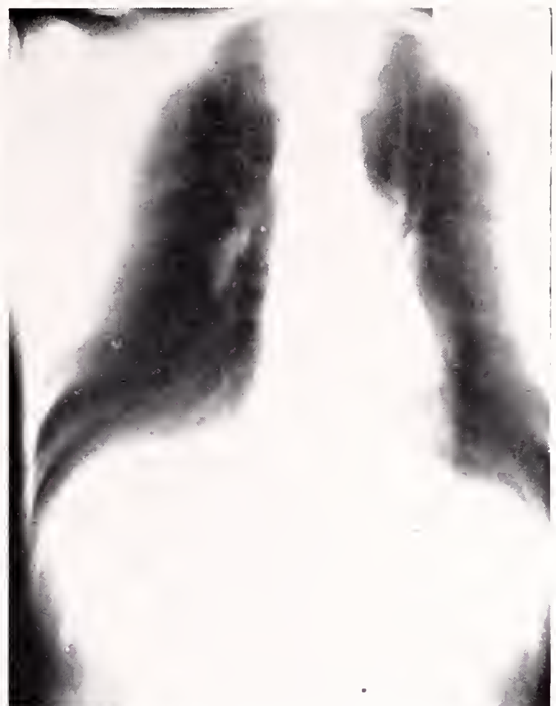

Figure 5: AP laminagram at hilar level in emphysema. The peripheral pulmonary vessels are sparse, small and abnormally tapered.

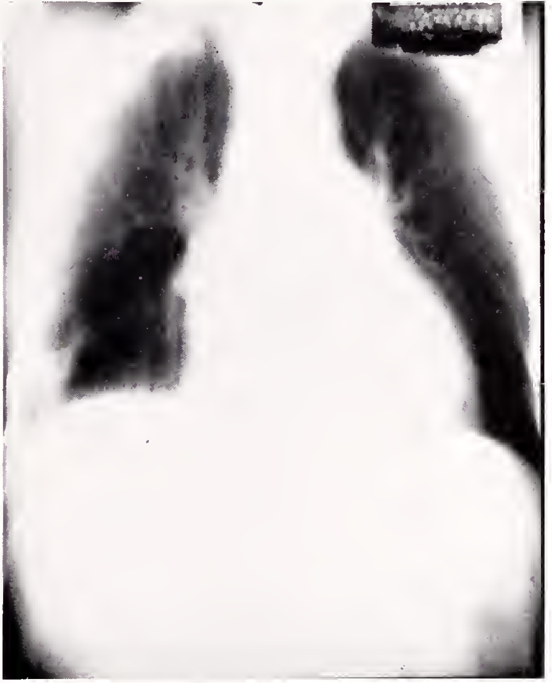

Figure 6: AP laminagram at hilar level in patient with a septic pulmonary embolus. The peripheral pulmonary vessels are normal in size, number and location.

Differential Diagnosis

There are several other conditions which lead to increased radiolucency on a chest film and may be confused with emphysema. It is obvious that absence of the pectoral muscles, an uncommon congenital anomaly, may present this picture. The same is true of the post-mastectomy state. The nature of the increased translucency in these instances becomes readily

apparent when the attending chest wall soft tissues are found to be absent. Scoliosis of the dorsal spine may present a similar picture but the striking abnormality in bone alignment immediately alerts one to the underlying problem. Congenital absence of one pulmonary artery leads to increased translucency of the affected side. Little difficulty is encountered in identifying this entity since the mediastinum and heart are displaced toward the affected side and the pulmonary vascular pedicle of the affected lung is diminutive or absent. From a strictly radiological point of view more difficulty is encountered in differentiating thrombosis of a main pulmonary artery, where there is no mediastinal shift. In these cases the hilar shadow is very prominent, contrasting with very small peripheral vessels. A similar picture is seen in some cases of true unilateral hypertrophic emphysema. Differentiation presents less of a problem to the clinician than the radiologist since physical signs in the two conditions are usually quite dissimilar.

Several examples have been reported in recent years of idiopathic unilateral hyperlucent lung,[5, 6] a condition which presents an x-ray picture reminiscent of unilateral emphysema. In this condition the affected lung appears more radiolucent than normal but is not increased in volume. The attending pulmonary vessels are small and at fluoroscopy the mediastinum is seen to shift on inspiration toward the involved side as occurs in obstructive emphysema. Although the bronchi are patent at bronchoscopy and bronchography the latter reveals a peculiar type of bronchiectasis. Blood vessels to the affected lung as demonstrated at angiocardiography are, indeed, reduced in number and caliber.

Although lobar emphysema of infancy, pulmonary cysts and postinflammatory pneumatoceles might be confused with pulmonary emphysema, particularly its localized bullous form, in most instances they do not present significant differential diagnostic problems.

The x-ray diagnosis is not difficult in a full blown case of emphysema. When all of the findings described above are present, the diagnosis can be made with great confidence. When the disease is less fully developed, and fewer of the findings are present, the accuracy of x-ray diagnosis decreases. Various assessments of the accuracy of x-ray diagnosis of empnysema have been made and the range of these assessments is rather wide. It has been said[7] there is 85% correlation between the x-ray diagnosis of emphysema and the one-second timed vital capacity. A rather careful study[8] has shown that plain film evaluation was 95% accurate in diagnosing the presence of emphysema when the disease was advanced, although determination of the degree of disability by x-ray examination did not always correlate with the clinical impressions and pulmonary function tests. In moderate emphysema, the plain film x-ray diagnosis of disease was 73% accurate, again with considerable disparity in the x-ray evaluation of the degree of disability. It is of some note that these same investigators found x-ray evidence of moderate emphysema in 23% of a control group who proved to have normal pulmonary function on further study.

It should be borne in mind that these studies were made on plain films. Certainly the accuracy of x-ray diagnosis of emphysema improves markedly with laminagraphy. With laminagraphy about 90% accuracy can be attained.[3] Differentiation between spasmodic asthma and hypertrophic emphysema with laminagraphy is relatively easy. Similar information can be obtained in a somewhat more vivid form by angiocardiography. This procedure is time-consuming, expensive, requires complicated equipment and is not without danger. Although plain films and fluoroscopy are valuable in the study of emphysema, laminagraphy is strongly recommended for any patient suspected of suffering from this disease. This simple and inexpensive maneuver will provide a dependable diagnosis in the vast majority of instances.

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Dependency: Normal and Pathological* **

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Dependency is not necessarily a pathological need, but becomes so when it is increased at the expense of other psychological factors. Mental health is a proper balance among the various psychological forces that constitute personality.

ONE RESTLESS and troubled night before the walls of Troy, Agamemnon, the leader of the Greeks, was unable to sleep. Concerned over the perilous position of his troops, he went to the tent of wise old Nestor to share his anxiety. In the course of their discussion Nestor could not refrain from a caustic comment about Agamemnon's younger brother, Menelaus, for being asleep at such a critical time and leaving all the work to Agamemnon. The latter, while informing Nestor that he had just found Menelaus up and about, none-the-less implicitly agreed with Nestor's criticism in these words: "Sir, another time I should urge you to chide him, for he is often lax and unwilling to be active—not that he hestitates out of fear or because of stupidity, but because he looks to me and waits for my prompting."

In the 2800 years that have elapsed since Homer's portrayal of Agamemnon's gentle disapproval of his brother's reliance upon him, the attitude toward dependency has changed little, if at all. We respect and admire the strong and self-reliant, and pity, even scorn, the weak and dependent person. In the field of medicine this attitude is particularly evident in the current concepts of dependency and dependency needs, which are invoked (especially in the theories of psychosomatic medicine) to explain the genesis of symptoms and the pathological reactions to illness and injury. The tacit assumption seems to be that dependency (and the passive attitude that often accompanies it) is pathological, and the term "passive-dependent character" used to describe patients is often invective rather than a diagnosis. Our reaction as physicians to our patients' dependency needs is an important and complex problem; our focus here, however, must be limited to the nature of dependency itself, and to its place in man's psychological functioning.

Representative Cases

Let us begin our investigation by examining two patients. Although each of these brief descriptions is that of an individual person, it represents a type of behavior pattern repeatedly observed by the psychiatrist and his colleagues.

1) M.S., a man of 42, lives with his mother. He has never married, preferring not leave home. He has not worked for 10 years, ever since the time of a hermorrhoidectomy. His mother supports both of them by working as a cleaning woman, and in addition takes care of her house and her son, making his meals, cleaning his room and doing his laundry. Occasionally he will help around the house if she is sick or will run errands for her to get the groceries, but in recent years because of phobias he has not liked straying far from home alone—in fact, he feels comfortable going places only when his mother accompanies him.

2) A.N., a man of 41, married and the father of an adolescent son, prides himself on his strength and independence. He has always been a self-reliant person. Even as a boy he had a paper route and did odd jobs to make his own spending money so that he would not have to ask his parents for help. He left home at 16 to

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work full time in order to "be on his own," and now as an adult, he always seeks out the hardest, most challenging kinds of work, volunteering for jobs that no one else dares attempt, or for tasks that other men have tried and failed.

He works long hours (often 12 to 14 hours a day) and refuses to take time off from work for vacations or for minor illnesses; furthermore, he is proud that he always does a conscientious job, giving his employers all or more than they require. He never likes to ask for help, and although always willing to lend a hand to someone else in need, he insists on "doing for himself" whenever he wants anything. He will not borrow money or things, and "does without" if he can't get whatever he wants for himself and by himself. He never confides his problems in anyone else, and on one occasion, when unemployed during a depression, he refused to take governmental relief, considering it "charity"; he preferred to starve if "he could not make his own way".

At first glance there is a world of difference between these two men, the one still living in the shelter of his mother's bosom, the other striking out courageously on his own. There should be little disagreement that the term "dependent" applies to M.S., and it is apparent that he is dependent to a pathological degree. Most men of 42, even if they have not married and assumed the responsibility of supporting a family, are at least working and providing for themselves. It is unusual to find a grown man, whose physical capacities are intact, so needful of his mother's presence that he has to have her with him when he ventures away from the house; and it is a rare man who would allow his mother to provide his sustenance and look after his physical needs. This is behavior characteristic of a two-year-old, not a forty-two-year old.

A.N., on the contrary, seems to live his life at the other end of the spectrum. He is strong, courageous, conscientious and self-reliant. Even the words used to describe him carry overtones of worth that lead one to admire him. And indeed the qualities so evident in him *are* of value to himself and to society. They have enabled him from an early age to have the things he wants—things that he might not have obtained had he relied on others to give them to him. They allow him to provide well for his family, and to achieve a certain amount of success and reputation in his work. They endow him with attributes that make him valued by others—employers like him for his skill, his initiative and his faithful conscientiousness. His friends like him for his honesty, and his altruistic helpfulness. In short, A.N. seems to be an ideal man.

Independence As Defense

A little reflection, however, raises the suspicion that there are flaws in the strengths so obvious in A.N. and others like him. There appears to be something exaggerated in his stance of strength—he is too set on showing no sign of dependence, of incapacity, of weakness. If one talks to the relatives or close friends of such people one's suspicions are confirmed: Those who know them well complain that they are "too independent," that they keep too much to themselves. They are, furthermore, often emotionally aloof; they will not allow others to help or to direct, even when the situation is entirely appropriate, or even demands it.

As physicians dealing with such people we soon discover the difficulties which their behavior as patients poses for our adequate management of their illnesses: Out of fear of showing weakness they hide serious symptoms, and compromise our diagnostic operations. They find it hard, if not impossible, to take orders even when these are necessary for the recovery of their health. They are often quite unable to remain inactive for the period required to heal a lesion—they leave the hospital against medical advice and return to strenuous work completely against the dictates of medical judgment. In short, characteristics of behavior that ordinarily are assets become liabilities when they are seriously ill.

What is more, if such people fall victim to a serious and crippling illness or injury that despite all their drive to activity forces them for long periods of time to remain invalided, one finds paradoxical behavior patterns emerging: They become excessively demanding of other people (doctors, nurses, families and others on whom they are forced to rely). They become dependent on others to a degree far in excess of the limitations to activity posed by their physical infirmities. And even when their physical lesions are healed so that they are ready to return to work and to resume their former life of activity, they persist in their pas-

sive and dependent behavior, complaining of symptoms, demanding help and support from others, refusing to do anything for themselves. They suffer from what is clinically termed a regressive reaction, and are now as totally helpless as they once were totally self-reliant. With their symptoms as an excuse, they have become as dependent and ineffective as our patient M.S.

If one explores the psychological structure of such patients, one discovers an interesting fact: Over and above its intrinsic value, their behavior pattern of independence serves a defensive function. Such people are so frightened by the idea of in any way being dependent on others that they lean over backward to be entirely the opposite—totally self-reliant. Although they appear to have had no dependency needs before becoming sick or injured, these needs become obvious once they are incapacitated. The incapacity does not simply create the needs—it uncovers and unleashes them. For the needs have always been there as a part of the patient's total personality structure; they have, however, been rendered inoperative and have been kept out of the patient's conscious awareness by his defensive reaction formation of excessive self-reliance and independence. Once they appear in the open around the focus of the symptoms of an injury or illness (which renders their usual defences of activity inoperative and invites the dependency needs into overt, conscious expression) the intensity and strength of the needs becomes apparent.

Universality of Dependency

Such observations of patients' psychological functioning tell us something of importance: Dependency is a universal human phenomenon. It is not in itself an abnormal or pathological need, but becomes so only when it has certain quantitative and qualitative characteristics.

No one is concerned over the total helplessness and dependency of the infant on his mother for every aspect of his physical and emotional needs. As the child develops, a drive (which appears to be a basic human impulse) toward activity and independent self-reliance makes its appearance. The child wants to do things for himself—to feed himself, dress himself, and often to do things beyond his abilities. The child's determination is often intense, and touching to observe—as one little boy said when his father remarked, "Shall I help you?" in the face of his struggle to do something obviously beyond his skills, "No! I help me!" And even as the child's capacities to take care of his physical needs have matured and developed, he still needs the love and emotional support of his parents. None of us ever outgrows these needs, no matter how effective and strong we become as adults. There are always times when we need concrete help for something beyond our capacities (the help of a doctor's special skills when we are sick, for example), and all of us need the love and emotional support of family and friends, especially in times of trouble. Such human dependence of one person on another is not pathological.

It becomes pathological in at least two ways. In the first place the intense dependency needs characteristic of the infant may persist, and (for a variety of reasons) the drive to autonomy may fail to develop. As the person grows into physical adulthood, his dependency becomes excessive, and is almost untempered by a weak drive toward self-reliance that has remained underdeveloped. On the other hand, a child may early in life develop a fear and mistrust of depending on others—again for a variety of reasons, one important factor being a failure on the part of others adequately to care for his needs. He tends more and more to rely on himself, excessively and prematurely, and the unsatisfied dependency needs, though increasingly pushed beneath the surface, remain potentially strong, just because they have not been adequately gratified.

In each of these cases, one aspect of the growing person's personality has been developed at the expense of the other. In the one, as exemplified by M.S., the dependency needs flourish and automony remains stunted; in the other, as seen in A.N., autonomy develops at the expense of the dependency needs. Although on the surface, each of these types of persons seems totally different from one another, they are seen, when one examines their character structure, to have certain features in common. And each of them has an unbalanced character structure, as contrasted with the normal person in whom dependency and automony have reached a more equitable equilibrium. The concept of a balance of the elements of personality structure is an important one, and we shall return to it later. But first we must examine one

other factor that frequently adds to the problems that exist in patients with the personality difficulties we have been discussing.

The Regressive Reaction

In the patient who suffers a regressive reaction, there is another paradoxical contrast beside that between his former strength and his present helplessness: Despite his dependent, demanding, often querulous behavior, he still thinks of himself as being essentially a strong, self-reliant person, and is convinced that he would be active now if it were not for his symptoms, on which he blames all his difficulties. Even though his actions belie him, he stoutly maintains that he wants to be active and self-reliant. ("I'd go to work tomorrow, Doc, if it weren't for these pains" is his repeated refrain.) In other words, his goal, his ideal of behavior for himself remains the same as it was before his injury occurred or his sickness began. What is more, recognizing how much his present state of invalidism falls short of his ideal, he often becomes quite depressed over the loss of his independence and chides himself for his weakness—not realizing how much of his predicament stems from the underlying dependency needs, of which he still remains unconscious. Furthermore, if we focus on his ideals for himself, we find that they are exceedingly lofty, demanding and uncompromising—he cannot and will not knowingly lower his standards of behavior under any circumstances, and his conscience pricks him sternly if he feels he has in any way fallen short of his ideals.

Superficially, the overtly dependent person, like M.S. would appear to have no such lofty ideals, and yet as one explores the psychological structure of this group of people, one finds that they, too, frequently have excessively high standards for achievement—goals of excellence, strength and perfection that are often way beyond their real capabilities. The obvious behavioral difference between them and the overtly independent group of people may be understood in part as follows: The latter feel capable of achieving their ideals and are often able to live up to their self-imposed standards for long periods of time. The former, on the contrary, are convinced from the start that they have not the capacity to gain their ideal goal—in the very act of trying to reach it, they are insecure, self-doubting, and convinced that their attempts can only end in failure. To obviate the pain of the anxiety and depression that accompanies this desperate insecurity they reach out to others for help and for reassurance—reassurance in the form of praise, of encouragement, of understanding, of forgiveness, of a sign that others still like them despite their shortcomings. A large share of their dependence on others is attributable to this insecurity of theirs in the face of their demanding ideals.

Although the problem of the difference in the response of these two groups to their ideals is an important one, it cannot concern us here. Our purpose in focusing on the nature of their ideals is to observe that for both groups they are excessively high, demanding, uncompromising and inflexible, and the self-judgment of individuals of both types is excessively severe when they feel they have not lived up to their self-imposed standards. Because of the rigidity of these standards, they are often forced into actions that are beyond their skills and physical capacities, or that are even harmful for the functioning of the organism as a whole. Or they are prevented from expressing and satisfying instinctual demands that are both pleasurable and beneficial. They become the victim of the tyrannical rule of *one* aspect of their total psychological functioning. Once again we are observing an imbalance in the individual's personality structure, resulting from the excessive development and strength of one part of it (in this case, the superego with its ego ideals and conscience), which makes its demands on the individual at the expense of the other parts of the structure.

Normal Balance

In the normal person there is a better balance of the functioning parts. In the face of an illness, for example, he is able to accept the dependency imposed on him by his incapacity, and to utilize the benefits of the dependent state to achieve his ultimate recovery and rehabilitation. By the same token, when he is physically able to return to activity, he does not cling to dependency, but is able to return to a state of self-reliance and strength.

There is a flexibility in his personality structure that enables him to adapt to circumstances as they require. Even in health there is a free give-and-take between himself and others, that

permits him comfortably to rely on others when he needs them and to do things for himself and for others when he is able. So too, his goals, his ideals and his conscience show a flexibility and adaptability—not that he is a hypocrite or an opportunist, but his goals are realistic as measured by his capabilities and skills, his ideals are a guiding principle for important decisions in his relationships with others without tyrannically imposing their standards where they are inappropriate, and his conscience, though a loyal guide and an often painful goad, does not cripple him with excessive or unduly prolonged sanctions.

The key words in our discussion here are "balance" and "proportion"; and it is our thesis that in the psychologically healthy person the parts of his psychological structure are in equitable balance. This does not mean that he is without inner conflict or strife, but that there is a just proportion of psychological functions in an equilibrium which permits him to adapt realistically to his environment and to make the fullest use of his human capacities.

As concepts, these are neither new nor strange to us, for we are accustomed to conceive of the various functions of the healthy physical body as operating within the boundaries of a homeostatic equilibrium. Our purpose here is to apply the idea of balance and proportion to the psychological as well as the physical functioning of the human being. In this framework, as we postulated earlier, dependency is not in itself a pathological human need. It becomes a pathological force only if its strength is excessive in proportion to other psychological functions, or if its expression is too greatly curtailed by psychological agencies that have become overgrown at the expense of dependency itself, throwing the psychological organism into an unhealthy imbalance.

The Greeks had a word—or better—a phrase, for it: "Meden agan"—"Nothing in excess." And this, perhaps better than any other, expresses a basic and guiding concept for mental health.

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The Place of Allergy in Internal Medicine*

JOHN D. LOVETT, M.D.

Owensboro, Ky.

This article deals with some practical aspects of recognizing and handling respiratory problems.

ALLERGY continues to be one of the least understood of the sub-special categories in the general field of internal medicine. Several things have tended to make this true. Continued lack of understanding of the basic mechanisms of allergy has fostered an empirical science. Didactic teaching in most medical schools fails to catch the interest of students. In general, practical application has been neglected in the teaching of allergy to medical students.

Confusing units of measurement for extracts used in allergy therapy often causes practitioners of the other branches of medicine to look upon it as having an element of hocus-pocus or forbidding complexity. Discouraging results of therapy may occur under an arrangement where the physician in primary charge of the patient is using extracts of unfamiliar content that are prepared by a consultant in a distant city. This could be likened to trying to control digitalis therapy or anticoagulant therapy using medications of unfamiliar content prepared by another doctor. It is not intended to criticize the role played by the increasing number of well trained allergy specialists. It is suggested, however, that general practitioners and internists whose communities are some distance from an allergist could provide better care for their patients if they would become sufficiently familiar with the common allergic disorders to be able to carry out routine skin testing and prepare treatment extracts.

With some effort a basic clinical understanding of allergy evaluation, testing and treatment is well within the grasp of any practicing physician. Such understanding will aid any practitioner in working better with an allergy consultant and can allow the particularly interested physician to evaluate, skin test and treat a number of common allergic problems.

There are a number of reasons why the physician charged with the general care of a patient who has an allergic problem should be conversant with the nature and treatment of allergic disorders. Prominent writers in the field of allergy emphasize the importance of a total understanding of the patient and his environment. Regular re-evaluation of the patient is recommended. The allergy patient commonly has complicating diseases such as emphysema, chronic bronchitis and coronary artery disease in the case of the older patient and various childhood diseases in the younger patient. These require regular follow up care and management with a background understanding of the allergic problem.

Allergens

When building up a patient's resistance to an allergen it is highly desirable to have only one or two allergens contained in a given injection. This allows quick detection of the offending substance when an undesirable reaction occurs and allows proper variation of the dosage level. Of additional importance is the fact that allergy patients are particularly prone to become attached to one doctor or clinic group. This handicaps one or the other doctor when the patient is seeing a specialist for allergy care and his family doctor for other care.

The allergy patient should be attended regularly by the doctor in charge of his allergy problem. If the patient is under the care of an allergy specialist, then he should receive his treatment of severe asthma attacks or other complications directly under the care of that

Presented at a meeting of the Kentucky Chapter of the American College of Physicians, September 18, 1962, during the Annual Meeting of the Kentucky State Medical Association at Louisville, Ky.

physician. If the patient is under the care of his local internist or general practitioner, then that doctor should be sufficiently oriented in the field of allergy to prescribe or alter therapy as the situation may dictate and not simply didactically follow instructions of a consultant.

Atopic Disorders

The reference in this discussion to allergic disorder implies the atopic disorders. These include bronchial asthma, hay fever, perennial allergic vasomotor rhinitis, urticaria, angioneurotic edema and atopic dermatitis. Allergic disorders of an atopic nature are those wherein circulating antibodies are present and an immediate wheal reaction occurs on skin testing. The circulating antibodies will result in a passive transfer phenomenon called a Prausnitz-Kustner Reaction. This occurs when serum of an allergic individual is injected into the skin of a non allergic subject. After an incubation period of 24 hours the recipient test site gives a positive immediate wheal reaction when tested with the offending allergen. This positive test becomes negative on repeated injection of the allergen, presumably because of neutralization of the originally injected antibodies. However, a positive wheal reaction is still obtained when the recipient test site is injected with a different allergen to which the donor allergic patient is also sensitive.

It has been estimated that about 6 to 10%[1] of the population has some allergic manifestation of the familial type. Likewise, a familial association is usually present in allergic diseases. Allergens are generally believed to be protein in nature for the most part and may be any of numerous substances in the patient's environment. As a general rule, however, allergic patients develop sensitivity against those allergens to which they are commonly exposed. The common allergens will vary in desert, tropical and temperate climates. In the Ohio Valley the common inhalant allergens are dusts, molds, animal and insect epidermals and pollen. The principal pollens are those of trees, grasses and ragweeds. English plantain, goldenrod and cocklebur and some others may be important in certain localities.

The allergic disorders most often seen by general practitioners and internists are seasonal allergic rhinitis or hay fever, perennial allergic vasomotor rhinitis and allergic or extrinsic asthma. Allergic skin disorders and gastrointestinal allergies are more difficult to evaluate, particularly as to the offending allergen.

The features of the allergic history and physical examination are of prime importance in ascertaining the allergic nature of a patient's complaints. In a positive allergic history the patient usually has a family history of asthma, hay fever or chronic sinus disorders. Attacks of repeated sneezing tend to occur with nasal allergy and this is associated very frequently with itching and tickling in the nose, soft palate and eyes. The nasal discharge is watery or seromucoid in character and does not become purulent unless secondary infection intervenes. Allergic wheezing is periodic. It often is associated with the allergic nasal symptoms and occurs commonly at rest. It may, however, be aggravated by exertion. Tickling in the throat and a scant clear expectoration suggests an allergic component when cough is the presenting complaint.

On examination, the allergic nasal membrane appears pale and boggy. The presence of mucoid polyps is strongly suggestive of allergic rhinitis. These are pale, bluish white in appearance and usually are found high in the nasal antra or may be seen in early development on the turbinates with the appearance of hydrops degeneration of the mucous membrane. The sinuses should be transilluminated to detect differences in opacity between the two sides. This can readily be done in any darkened room by removing the lens head of an ophthalmoscope and holding the lighted bulb gently against the floor of the orbit while the patient's hard palate is viewed through the open mouth.

Generalized bilateral high pitched expiratory wheezes are present during asthmatic episodes. These are generally absent between episodes of asthma but often may be heard with forced exhalation or voluntary coughing when the patient does not have overt dyspnea. Predominance of eosinophiles in the nasal secretion is indicative of allergy and can be checked by having the patient blow his nose into a piece of wax paper and checking microscopically a Wright's stained smear of the secretion. Patients with asthma should have a timed vital capacity before and after inhaling 1:200 Isuprel.® The normal person will exhale approximately 80% of his air in one second and all of

it in three seconds while the asthmatic shows obstruction and slowing in exhalation even though the total vital capacity may be normal. This obstruction is decreased following the inhalation of the 1:200 Isuprel. The chest should be x-rayed. An additional x-ray film should be taken immediately after forced expiration where a foreign body or bronchial obstruction by polyp or carcinoma is a possibility.

Skin Tests

After the allergic history and examination, as well as a general history and physical exam and a review of the patient's environmental setting, skin tests for the common allergens should be done. Details of technique will not be discussed except to say that it is the opinion of this writer that intradermal testing with the common pollens, molds and house dust is the preferable method. Danger of serious reaction to intradermal testing is generally mentioned by those who recommend scratch testing. However, the accuracy of intradermal tests is greater[1] and it is felt that a markedly sensitive individual can be recognized from the history and physical exam. Adjustments in the dilution of the initial skin test extracts can then be made.

Tests using a representative group of the animal epidermals, common chemicals such as pyrethrum, printer's ink and glue, as well as the most common food allergens are checked using the scratch technique. Dry powdered allergens are recommended for scratch testing. Using a toothpick, these are mixed on the skin with a drop of 0.1 normal sodium hydroxide. Powdered allergens are more cumbersome to use and do not allow mass testing techniques. However, they have the advantage of maintaining reliable potency for long periods of time.

Commercial Supply Houses

Excellent commercial supply houses now provide sterile vials, properly buffered diluents, reliable test allergens and treatment allergens. *Center Laboratories,* Port Washington, N. Y., can be well recommended as a supplier of testing and treatment extracts. *Sharp & Sharp,* 3402 Norton Ave., Everett, Wash., is recommended as a supplier of dry powdered allergens for scratch testing. Specially prepared house dust extract by *Endo Laboratories, Inc.,* Richmond Hill, N. Y., is recommended for house dust testing and treatment.

Endo Dust and allergens from *Center Laboratory* were used in a study by Kern and Goldman reported in the Annals of Internal Medicine of November 1961.[2] They used these extracts in order to study the incidence of positive immediate wheal reactions to ragweed, grasses, trees, dust and feathers in normal individuals with no personal or family history of an allergic disorder. When 100 such patients were tested, 9% showed a positive intradermal test to one or more of the extracts. Seven of these, or 77% of the positive tests, were to the house dust. When these same extracts were used in testing 40 individuals with a definite seasonal history of rhinitis, asthma or both, 36 or 90% gave positive intradermal tests to one or more of the extracts.

It is suggested that already prepared dilutions of single allergens can be obtained for intradermal testing. These should consist of giant and short ragweed, the common molds and a representative group of the local grasses and trees. Other weeds such as cocklebur, goldenrod and plantain may also be obtained. A test dilution of 1:4000 Endo 1:40 house dust can be prepared from the bulk dilution. For treatment purposes vials of bulk extracts are ordered in the maximum strength provided. This is usually a 1:10 dilution or about 50,000 Protein Nitrogen Units per cubic centimeter. The concentrated bulk extract is then diluted as needed. The more concentrated solutions maintain potency for a greater period of time. It is satisfactory to use bulk treatment extracts in the form of mixtures of the common varities of grasses, trees, molds and ragweeds.

Units and Nomenclature

One of the practical obstacles to the practitioner in carrying out allergy testing and treatment is a lack of understanding of the units of measurement of strength for various allergen extracts. There is confusion in units and nomenclature here due to early leaders in the field of allergy having devised their own units of measure. Pollen Units, Noon Units, Protein Nitrogen Units, Total Nitrogen Units and Total Milligrams of Nitrogen are used for measurement as well as the method of Dilution Measurement.

It is suggested that physicians familiarize themselves with the Protein Nitrogen Unit as well as the Dilution Measure. The Protein Nitrogen Unit seems to give a more concrete idea of the amount of allergen involved in testing and treatment. The Dilution Measure is more practical to use for preparing various dilutions of extract. One Protein Nitrogen Unit is equal to that amount of allergen which contains ten millionths of a milligram of protein nitrogen. One milligram of protein nitrogen, therefore, equals 100,000 Protein Nitrogen Units. One milligram of pollen yields about 500 Protein Nitrogen Units.

The Dilution Measure is an expression of the ratio of weight of dried defatted allergen, as expressed in grams, to volume of extracting solution expressed in cubic centimeters. In other words, a 1:50 dilution represents one gram of material extracted with 50 cubic centimeters of solution. Roughly speaking, one cubic centimeter of a 1:50 dilution is equivalent to 10,000 Protein Nitrogen Units. Generally, one, 10 or 100 Protein Nitrogen Units of allergen are used for intradermal testing.

In treatment step-like increases of allergen are given, starting with less than the amount that gives a positive intradermal test and increasing to a maximum dose of approximately 5,000 to 8,000 Protein Nitrogen Units or to the maximum dose that the patient tolerates without significant reaction. It is desirable to give each allergen in a separate injection as long as the dose is being progressively increased. The patient must wait in the doctor's office for at least 20 to 30 minutes following each series of injections. The physician should personally check any local reactions and adjust succeeding doses accordingly.

Perennial therapy is recommended. In this schedule of treatment the patient is brought to a maximum or treatment level by step-like increments in the strength of injections and thereafter is maintained on a maximum treatment dose the year around with injections given at intervals of two, three or four weeks. Weekly injections should then be given for about three weeks before the patient's allergic season. It is often found that during a heavy pollen exposure period the strength of the maintenance injection must be decreased to about one-half.

Methodology in testing and hyposensitization of the allergic patient has been emphasized because of the general lack of understanding of this by the practicing physician. However, drug therapy to suppress the symptoms of an allergic reaction as well as a good avoidance program to eliminate as much as possible of the offending allergen may be just as important aspects of allergy management. In some instances these measures may postpone or eliminate the need for hyposensitization therapy.

For the physician interested in acquiring proficiency in the management of allergy problems, a number of excellent texts are available. One of these, a text entitled, *A Manual of Clinical Allergy* by Sheldon, Lovell and Matthews of the University of Michigan bears particular recommendation.[3] This text has not only a well written outline of the various allergic disorders but also goes into practical detail concerning the technique and equipment necessary for testing and hyposensitization. It includes a comprehensive listing with complete addresses of the principal suppliers of material and equipment and an excellent list of reference books and journals.

Several schools provide good courses of from one to four weeks duration, aimed at familiarizing the general physician with allergy techniques. The Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago; the Temple University Medical Center, Broad and Tiega Streets, Philadelphia, and the Department of Allergy, Montefiore Hospital, Pittsburgh, each have one or more such courses each year.

It has been the purpose of this paper to present the viewpoint that it is pracitcal and helpful for the internist and general practioner to familiarize themselves with the evaluation and management of the common allergy problems. Such knowledge is particularly valuable when the distance from a full-time allergist is such that treferred allergy patients cannot be under the continuing observation of the allergy specialist. Some of the practical points involved in allergy evaluation, testing and treatment as encountered in the practice of general internal medicine have been covered.

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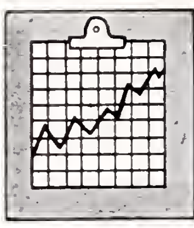
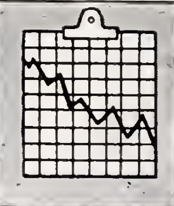


CASE DISCUSSIONS
From The
University of Louisville Hospitals



Louisville General Hospital

The Causes of Bulging Fontanel

Hermogenes B. Puruggaanan, M.D.*

In infancy the posterior and lateral fontanels are usually obliterated by the sixth week. The anterior fontanel, though, remains patent up to between the ninth and the sixteenth month of life.[1] Pulsation of this fontanel is a normal finding, and in fact points against increased intracranial pressure.[2]

One of the few neonatal signs requiring prompt diagnostic action is a bulging fontanel. When associated with opisthotonus or stiff neck, one is especially obligated to try immediately to exclude meningeal irritation from infection, hemorrhage, or a brain stem irritation.[2]

The purpose of this paper is to enumerate the multifarious causes of a bulging fontanel that vary from the serious to the most benign; the intrinsic and the extrinsic etiologies, and, in passing, a few iatrogenic causes. The differential diagnosis includes the following:

Meningitis
Hydrocephalus
Brain abscess and tumor
Cerebral hemorrhages
Hypophosphatasia
Lead encephalopathy
Tetracycline therapy
Roseola Infantum
Hypoparathyroidism
Vitamin A deficiency and excess
Benign intracranial hypertension
Normal baby with incessant crying

Other documented causes of intracranial hypertension are Addison's disease, marked iron deficiency anemia, pulmonary emphysema, and post-adrenalectomy steroid therapy.

A case of Roseola Infantum mimicking meningitis is now presented as pertinent to this discussion.

Case History (Case #5 Hospital)

M.D. is a six-month-old Negro girl who was in good health until the night before admission when she began coughing and vomiting and was febrile. The following morning in clinic it was evident on examination that the child was irritable and had a bulging fontanel. An admitting diagnosis of meningitis was made.

On admission the patient had a temperature of 102.4 degrees F., pulse rate of 130/min., and a respiratory rate of 30/min.

Physical examination revealed an irritable child, somewhat dehydrated, but not acutely ill. The anterior fontanel was tense and bulging but no nuchal rigidity was elicited. Small, shotty posterior cervical and large suboccipital nodes were palpated. The posterior pharynx was mildly hyperemic. The central nervous system examination was negative.

Laboratory findings—W.B.C.: 10,873/cu. mm. with 45% polymorphonuclears, 49% lymphocytes, and 6% monocytes; hemoglobin: 10.6 gms%; urinalysis: normal. Lumbar puncture revealed an opening CSF pressure of 150 mm. H_2O and a closing pressure of 75-80 mm. after 3 cc. of crystal clear fluid was obtained. No white cells were seen; protein: 20 mgs%, sugar: 84 mgs%.

Course in hospital: The child was placed in a croupette; antibiotics were withheld. The anterior fontanel felt soft the following day. The patient continued to have spiking fever up to 104 degrees F. for three days. On the fourth hospital day, almost concomitant with the erup-

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tion of a fine maculopapular erythematous rash confined mostly to the trunk and neck, the fever receded by crisis. On the fifth hospital day the child was discharged afebrile and with no rash.

Discussion

The diagnosis of Roseola Infantum was made from the character of the fever, the maculopapular rash, the suboccipital nodes, the leukocytosis and the relative lymphocytosis. Although in this child's case she presented what one might label as "benign" intracranial hypertension, one must, however, bear in mind that Roseola Infantum is not always a disease of benign prognosis.

Burnstine and Paine[3] report on the transient and permanent neurologic sequelae of this disease. Meningismus and/or meningo-encephalitis during the preeruptive febrile period in two out of four cases showing cerebrospinal fluid pleocytosis have been mentioned by Berenberg, Wright, and Janeway[4]. A high incidence of convulsions during the acute illness has been cited by Moller[5], stating that the occurence is much higher than one would expect in febrile illness in general. Oski[6] reported two cases of Roseola Infantum which presented with bulging fontanels. He admitted that no definite mechanism can explain this phenomenon except the possibility of encephalitis, cerebral edema, or some dysfunction in the normal mechanics of cerebrospinal fluid production or reabsorption. On the latter point little information is available.

Regarding the other causes of bulging fontanel, the most common are secondary to meningitis and subdural hematoma[7], together with the other intracranial diseases which are self explanatory.

The occurence of bulging fontanel following tetracycline therapy is not as uncommon as has been suggested. Fields[7] reported two cases following therapeutic doses of tetracycline-phosphate complex one to four days after the institution of therapy. Withdrawal of tetracycline in both cases was associated with prompt return of their fontanels to a normal state while no other causes for intracranial hypertension were found.

Hypovitaminosis A (an unusual occurrence, especially if one notes that only two vitamins—C and D—need be given as a supplement in infancy) can also produce a bulging fontanel. This state as illustrated by Bass et al[8], Cornfeld and Cooke[9], occurs specifically in cases wherein
and Cooke[9], occurs specifically in cases wherein
"milk allergy" is implicated and consequently without added Vitamin A. Hypervitaminosis A, as a cause of bulging fontanel, is suggested in Europe and South America where patent preparations consisting of 350,000 "U" Vitamin A and 300,000 I.U. of D_2 are given parenterally in the treatment of rickets. Marie and See[10] reported the onset of symptoms from 12 to 48 hours following such medication. It should be noted, however, that very large quantities of Vitamin A have to be given before untoward effects are produced.

Hypophosphatasia, a metabolic disorder involving infants in whom there is defective calcification of bone matrix associated with low levels of serum alkaline phosphatase, has also been reported to cause bulging fontanel by Fraser et al.[11]

Other disease processes that have been noted to produce intracranial hypertension include pulmonary emphysema[12], explained by a high plasma CO_2 producing cerebral vasodilation and pseudotumor cerebri, or benign intracranial hypertension, [13, 14] either "otitic," when otitis media precedes or accompanies the syndrome; or "toxic," when no such association is recorded. In these cases several possible explanations have been made, notably thrombosis of the major sinuses or thrombophlebitis of the superior longitudinal sinus. These theories are unlikely however, since other neurologic signs usually associated with such pathological processes are absent.

Other causes include Addison's disease,[15] marked iron deficiency anemia,[16] and adrenal steroid therapy in asthmatics.[17]

Clearly, much can be added to this list of differential diagnosis. The long list of "benign" causes, however, should not detract one from treating each case of bulging fontanel initially other than as an emergency.

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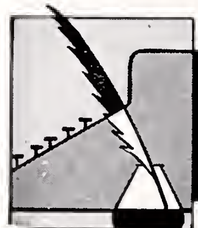

EDITORIALS

Cooperation for Improvement of Medical Care*

UPON MY installation as President of the Kentucky Hospital Association I made these remarks:

> *"There are many health and hospital problems before all groups represented here tonight, the solution to which is of common interest and the ultimate goal identical to all. The individual efforts of organizations have, however, in many instances been divergent and unrelated to the point that at times would seem to be at cross purposes.*
>
> *This does not necessarily have to be so. I invite the leadership of all organizations meeting with us this evening to join us in a course of mutual understanding, cooperative planning and unified diligent action which can achieve the goals we all pursue."*

During the past two and one-half years it has definitely been established that the Kentucky State Medical Association and the Kentucky Hospital Association can arrive at a mutual understanding, plan cooperatively and then act with diligence. Great benefits have already been derived from our cooperative efforts.

Additional hospitals of the state have been approved by the Joint Commission on Accreditation of Hospitals during the past year. Three of these had the significant assistance of the "dry run" accreditation teams consisting of physicians, hospital administrators and medical record librarians of the state. These teams were initiated through a joint effort of the Medical Association and the Hospital Association. Careful planning and extensive orientation of their members was necessary, all of whom functioned without compensation during their "dry run" accreditation surveys.

Representatives of both organizations worked long and in close harmony to assist a community in correcting deficiencies that threatened closure of its hospital. As a by-product of this unfortunate situation, a special committee of medical and hospital representatives has prepared minimum requirements for a medical record which were approved by the governing bodies of each group, then recommended them to the State Board of Health as an addition to the hospital licensure requirements.

The Hospital Association spent two years in developing a Guide For the Release of Information from Medical Records. Before it was recently released for publication it was thoroughly examined by various segments of the Medical Association and the state organization of Medical Record Librarians, then put into circulation with the endorsement of both organizations.

Hospital administrators and physicians in Kentucky are now sitting together in an organized way to discuss the complex and confusing problems of disaster planning. There is no doubt but what the combined thinking of this group will make contributions of the utmost significance to the logical and practical direction of this planning.

The establishment of proper professional relationships in nursing home care has been a topic of mutual interest and discussion, and groundwork has been laid for definitive practical action in the near future.

These achievements are certainly proof that with the proper climate of understanding and sincere intent our two organizations can work together and with others to further the progress of health care.

We have, however, only begun. Continuing effort in such fields as nursing home care and disaster planning has already been initiated. There still are areas which should be of mutual interest that remain dormant. Many aspects of hospital nursing fall within this category. As plaguing as the nursing shortage is and as vital

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**In commemoration of National Hospital Week, May 12-18, the Journal is happy to present this guest editorial by Otis L. Wheeler, president of the Kentucky Hospital Association and administrator of Louisville Jewish Hospital.*

as it is to all concerned with medical and hospital care, no recent record has been found of our state's medical organization, hospital representatives and nurses' groups joining together in an effort to study, then do something about it. As inter-related and inter-dependent on each other as medical practice, nursing care and hospital service are in the overall treatment of a patient, there seems to have been no combined effort to conduct educational programs leading to more sound mutual understanding and knowledge. If something definitive were undertaken in only these two areas, a real contribution to health care could be made.

The matters of third-party financing of hospital and medical care with its ramifications of bed utilization, preventive medicine, home care, out-patient treatment and insurance coverage; community planning of services and facilities; nursing practice and medico-hospital economics, all suggest most worthwhile avenues to mutually explore.

The sincere interests of both organizations to achieve the most progress in better health care for the people of our state has definitely been demonstrated during our recent cooperative efforts. Probably the greatest achievement of these has been the demonstration of the fact that we can deliberate together with shared trust, respect, integrity and good will.

The Physician and the President's Mental Health Proposals

THE medical profession has been and will be much involved with the planning and development of the new community mental health program being proposed by President Kennedy.

The plan foresees a full range of mental health services—in-patient and out-patient care, diagnostic consultations, rehabilitation services and help to schools, courts, ministers, general hospitals, etc., in the management of mental health aspects of their work. The President's proposal would provide for the construction of community mental health centers generally in association with existing community general hospitals. In-patient facilities for the mentally ill would be only part of the program, with offices, shops, etc., either in the hospital or nearby where the rest of the center's activities could be carried out.

Payment would be by private fees, insurance programs, third party plans and by some public support for indigent persons. No one would be sent to a state mental hospital until after he had been given 60-90 days prior treatment in the community mental health center and it was determined that he needed long-term care.

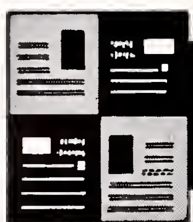
Manpower would likely be available once the centers were constructed just as other specialists have come into our communities after Hill-Burton built adequate hospitals. There is provision in the President's program for training, also.

The American Medical Association held its first Congress on Mental Health in Chicago in October 1962, to call attention to the seriousness of the mental health problem. Eleven Kentuckians attended that meeting. At the Ninth annual meeting of chairmen of mental health committees of state medical associations held in Chicago, March 1-2, 1963, it was announced by F. J. L. Blasingame, M.D., AMA executive vice president, that the American Medical Association endorses President Kennedy's mental health proposal.

At that meeting it was urged that state medical associations take strong leadership together with the state mental health program directors in developing the long range plans for such community mental health centers.

Here in Kentucky, the State Department of Mental Health is just beginning its planning work for this comprehensive community mental health program. The Department has asked for help from the Kentucky State Medical Association and will need the assistance of physicians throughout the State in developing the plan and in bringing into being these community mental health centers. We urge our local medical societies to take leadership in this program.

H. L. McPheeters, M.D., Commissioner,
Department of Mental Health
Frank M. Gaines, Jr., M.D. Chairman,
KSMA Committee on Mental Health



SPECIAL ARTICLES

The Postgraduate Program for Cuban Physicians in Exile* **

JUAN M. PORTUONDO, M.D. ***

Miami, Fla.

AS AN introduction to the report on The Postgraduate Program for Cuban Physicians in Exile, I shall explain briefly the reasons why this program came into effect.

By the end of 1959 it became evident that the democratic ideals proclaimed by Castro, before he came into power in Cuba, were merely a camouflage for Communism. Most of the Faculty of the University of Havana openly opposed the communist take-over of the University. Because of this we were ousted and forced to flee with our families from Cuba to escape prolonged imprisonment or even execution. Most of us settled in Miami where, by December 1960, more than one-third of the Medical Faculty and more than 200 Cuban physicians were in exile in the Greater Miami area. Due to licensure bylaws, citizenship requirements, etc., most of us were unable to utilize our specialized knowledge to help the United States meet its great need for more physicians and to support ourselves and our families.

Members of the Faculties of the Medical Schools of Havana and Miami became increasingly concerned about their responsibilities (as Faculties) to try to preserve that professional knowledge and talent of the exiled physicians and, at the same time, help the United States meet its responsibilities as leader of the Free World. That is why the Faculty of Medicine of the University of Havana in Exile came into being and why a joint program of bilingual postgraduate medical education was launched. It was also thought it would provide a unique opportunity for research on medical education.

My presentation this morning shall summarize the main results of the first bilingual postgraduate course; three more have already been offered. I am deeply indebted to Ralph Jones, Jr., M.D., chairman of the Department of Medicine of the Medical School of the University of Miami, for the facilities awarded to me for this presentation. It is only fair to say that he deserves most of the credit for this whole Program.

Methods of Control of the Program

A. Educational Measurements.

Comprehensive examinations, part of which were printed in Spanish and part in English, were administered at the beginning and at the end of the teaching program in an attempt: 1. To define the educational task; 2. To design the total curriculum to meet the specific needs of the group and of each individual, and 3. To evaluate the effectiveness of the total educational effort and of its component parts. The answer sheets were scored and analyzed by the National Board of Medical Examiners.

The individual questions in the National Board of Medical Examiners' examinations had been classified as to the category of medical knowledge (subject-matter category) they were designed to measure, and similar categories were established for the American Medical Qualifying Examinations. The performance of Cuban exiled physicians was compared with that of 3,000 senior American medical students in similar tests.

B. Curriculum.

A total of 57 didactic lectures was given from 7:30 to 9:30 p.m. each Monday, Wednesday and Friday evening, January 16 through March 24. Most of these lectures were given in English with simultaneous translation into Spanish. In addition, the exiled physician-students were divided into small groups of 8 to 10 and assigned to a member of the Faculty of Miami School of Medicine. These tutorial groups met at least once a week for one to three hours to discuss the matters covered during the week. Each physician-student was given a copy of

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*Presented at the First Scientific Session of the Annual Meeting of the Kentucky State Medical Association at Louisville, September 18, 1962.

**(Author's note): This paper explains the common effort of Miami and Havana Medical Schools to help exiled Cuban physicians pass the ECFMG examinations as a means of enabling them to support their families and meet the U. S. physician shortage.

***Professor of internal medicine, University of Havana Medical School, and visiting professor of medicine, University of Miami Medical School.

Cecil-Loeb Textbook of Medicine printed in Spanish.

Members of the Faculty in Exile of the University of Havana presented elective classes every day. A total of 80 hours a week of didactic-tutorial teaching was provided in this way.

At the same time two intensive courses of instruction in English were presented for the exiled physicians on Tuesday and Thursday evenings and Saturday afternoons.

Results

Initial examinations (January 1961) showed that the group mean scaled score was 60.9 on internal medicine; 58 on surgery (both tests printed in Spanish), and 60.2 on the ECFMG (printed in English), which results were 20, 22 and 25 scaled score points less, respectively, than the mean performance of senior American students on the same examinations.

Final examinations (March 1961) showed that the group mean scaled score was 69.1 on internal medicine; 65.4 on surgery (both in Spanish), and 69.5 on the ECFMG (printed in English), which results were 13.1, 16.6 and 13.4 scaled score points less, respectively, than senior American students.

One week after the end of the teaching program (April 4, 1961) 157 physicians who participated in this program completed the official American Medical Qualifying Examinations (AMQ) 16. The performance of this group (mean scaled score) was 71.2. One hundred and six (68%) achieved a scale score of more than 70. Fifty-one (32%) achieved a scale score of less than 70, i.e., failed the examination.

The mean performance of the Cuban physicians in the various subject matter categories in internal medicine (printed in Spanish), in January, and in the ECFMG test (printed in English), showed that the group of Cuban physicians had more information about dermatology and cardiology than they had about renal and infectious diseases, as measured by the test on internal medicine.

Similarly, the group had more information about obstetrics-gynecology and pediatrics than they had about surgery and basic sciences, at the start of the educational program. On this basis the curriculum was weighted in favor of renal diseases, infectious diseases, surgery and basic sciences, at the expense of dermatology, cardiology, pediatrics and obstetrics-gynecology.

The performance of this group of Cuban physicians on the examinations given at the end of the educational program in internal medicine (in Spanish), and the American Medical Qualifying Examinations (in English), showed a greater improvement in mean performance in the categories which were weighted in the curriculum, as could be expected.

The mean performance of this group of Cuban physicians compared with that of senior American medical students clearly demonstrated that, while Cuban physicians were leading in such subjects as cardiology, hematology, neurology, dermatology and legal medicine, the senior American students were leading in digestive diseases, infectious diseases, genitourinary diseases, nutrition and endocrinology, and psychiatry, while in respiratory diseases and musculoskeletal diseases both groups showed similar performances.

Since the questions in the AMQ examinations are generally easier than those in the NBME examinations in internal medicine, it is assumed that any individual who made a higher score on the examination printed in Spanish in internal medicine than he made on AMQ printed in English had sufficient language barrier to prevent him from demonstrating his knowledge of medicine optimally on the examination in English.

To measure the effect of this language barrier, both the extent of knowledge of internal medicine (as measured by the examination in internal medicine, in Spanish) and the presence of a language barrier (as defined above) at the start of the educational program were related to performance on AMQ 13, in English, at the end of the educational program.

The data show that nearly all of the physicians who had sufficient knowledge of internal medicine at the start of the course to make a score of 65 or better on the examination in Spanish, subsequently made a passing grade on AMQ 13. In his group the presence or absence of a language barrier had little or no effect on ability to achieve a passing grade on the AMQ examination in March. On the contrary, in those individuals who made a score of less than 65 on the examination in Spanish, in January, such a language barrier had a very great influence on their subsequent performance on AMQ 13. Of the 38 physicians with no language barrier who made a score of less than 65 on the initial examination 85% made a passing grade on AMQ 13 in March; but only 17% of 64 of such physicians with a language barrier made a passing grade on AMQ 13 in March.

Language Barrier

Another measure of the language barrier in this group of physician-students may be obtained by comparing the cumulative-frequency curves of the scaled scores achieved on the examinations in internal medicine, printed in Spanish, and the AMQ examinations, printed in English. The scaled score achieved on the examination in internal medicine (printed in Spanish) reflects the extent of the examinees' knowledge of medicine without the interference of a language barrier. That on the AMQ, printed in English, measures the medical knowledge in a similar manner, but the scaled score achieved is also influenced by the examinees' ability to demonstrate their knowledge of medicine using the English language.

In senior American medical students the mean performance on AMQ examinations is approximately seven scaled scores points higher than that in internal medicine. These students, of course, suffer no language barrier. With this information it is possible to plot the theoretical cumulative-frequency curve of the performance of a group of examinees on the AMQ examinations from their performance on the examinations in internal medicine, provided there were no language barrier.

That cumulative-frequency curve of the performance of this group of Cuban physicians on AMQ 14, at the start of the course (January 1961) crosses the cumulative-frequency curve of the performance on the examinations in internal medicine, at the 55%

level. Hence, 55% of this group achieved a higher score on the examination in internal medicine, printed in Spanish, than they achieved on the AMQ 14, printed in English.

The difference between the actual and the theoretical cumulative frequency curves for AMQ 14 is a quantitative measure of the language barrier in this group. It is also demonstrated that the magnitude of the language barrier is markedly less in those individuals who have the greatest knowledge of internal medicine and that those individuals with the least knowledge of internal medicine (as measured in their native language) have the greatest language barrier. Whether this means that those physicians from Cuba with the greatest knowledge of internal medicine were most likely to learn English because of a higher motivation or greater ability to learn, etc., or whether the fact that they knew English resulted in their reading the English medical literature as well as the Spanish and this resulted in a greater knowledge of internal medicine, is uncertain at this time.

At the end of the program (March 1961) the cumulative-frequency curve for the AMQ examination crosses the curve for the examination in internal medicine at the 30% level. The extent of the language barrier is markedly less than it was in January. This is largely the result of the remarkable effectiveness of the language teachers and of the extremely high motivation of this group in studying English. Again, the same inverse relationship between knowledge of internal medicine and the extent of the language barrier is demonstrated.

Conclusions:

1. This program provided several hundred Cuban physicians in exile the opportunity to utilize part of their time to increase and refresh their professional knowledge; facilitated their study of the English language and helped them out of their emotional and financial despair by enabling them to earn again their support through their life-long practice of medicine and, at the same time, helped the United States to cope with its physician shortage.

2. This program did not provide the data of performance of a group of practicing physicians in the United States of similar age, years out of medical school, specialization, very unusual and most unfortunate emotional and financial situation, etc., and, for these reasons, a valid comparison cannot be drawn between exiled Cuban physicians and senior American medical students.

3. This program lent support to the evidence that the ECFMG examinations are performing the functions for which they were intended.

4. This program provided a unique opportunity for members of medical faculties from different cultures to exchange information about teaching methods and conduct research on the effectiveness of mutually planned collaborative teaching effort, laying, to a certain extent, the foundation stone for more ambitious plans within the scope of the Alliance for Progress. It was a means of bringing closer friendship and better understanding among the Freedom-loving peoples of this Hemisphere in their fight against the increasing challenge of Communism as the best way to preserve America as "the land of the free and the home of the brave."

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ORGANIZATION SECTION

Doctor Gardner on Program For AMPAC Workshop May 18-19

Hoyt D. Gardner, M.D., Louisville, chairman of KEMPAC (Kentucky Educational Political Action Committee), will be one of the speakers during the AMPAC (American Medical Political Action Committee) Workshop at the Edgewater Beach Hotel, Chicago, May 18-19. Doctor Gardner will address the session on "Duties of State PAC Officers."

A group of eight to 10 Kentuckians are expected to attend the workshop which is intended to prepare those active in the state organizations to deal with organization, membership, legal and financial problems. Representatives of the various states attending will have an opportunity to discuss problems peculiar to their particular localities.

There will be a premiere showing of "The Barnstormer," the AMPAC 1963 educational film which will be available for use by state PACS. The workshop will consider political aspects of 1964, the importance of women in its efforts, membership campaigns and ways of improving state PAC organizational activities.

Wives of physicians are particularly encouraged to attend, AMPAC officials said, and pointed out although AMPAC and state PACS are medicine's political arms at the national and state levels, they are separate and apart from organized medicine.

AMA Sessions To Cover Common Problems

The latest information on some of the most common problems that confront physicians will be presented at eight general scientific sessions during the annual meeting of the American Medical Association in Atlantic City June 16-20.

Heart attacks, strokes, cancer, peptic ulcer, heredity, obesity, venereal disease, and painful back will be covered in lectures or panel discussions. Maurice T. Fliegelman, M.D., Louisville dermatologist, will participate in the discussion of medical genetics.

The third annual Multiple Discipline Research Forum will be held Tuesday, Wednesday and Thursday during the annual meeting. A series of 100 scientific papers will be presented under six general headings.

Meetings for May

The annual meeting of the Kentucky Surgical Society will be held May 17-18 in Lexington at the Campbell House.

The Second Kentucky Conference on Poisons and Poison Control and the First Kentucky Conference on Environmental Toxicology and Occupational Hygiene will hold a joint meeting May 22-23 at the Kentucky Hotel in Louisville.

For further information pertaining to both meetings, consult the April edition of the Journal.

10th Trustee District To Meet in Lexington May 14

N. Lewis Bosworth, M.D., Lexington, chairman of the Council on Communications and Public Service of the Kentucky State Medical Association, and Hoyt D. Gardner, M.D., Louisville, chairman of KEMPAC (Kentucky Educational Medical Political Action Committee), will address the May 14 meeting of the 10th Trustee District at Good Samaritan Hospital, Lexington, at 7:30 p.m.

Douglas E. Scott, M.D., Lexington, is trustee for the 10th District.

Doctor Gardner's subject will be "Fish or Cut Bait" and Doctor Bosworth will speak on the subject: "Medicine and the Current Legislative Picture."

The Second Trustee District meeting was held at Owensboro, April 11. Speakers were David M. Cox, M.D., KSMA president, and Doctor Gardner. Trustee for the second district is Howell J. Davis, M.D.

On April 23, the Third Trustee District held a meeting at the Hopkinsville Country Club. Doctors Cox and Gardner addressed this session, presided over by Third District Trustee Gabe A. Payne, Jr., M.D., Hopkinsville.

The meeting of the Fifth Trustee District was addressed by Mayor William O. Cowger of Louisville, and K. P. Vinsel, executive secretary of the Louisville Chamber of Commerce. It was held at Louisville on April 15. Fifth district trustee is Carlisle Morse, M.D., Louisville.

Doctor Scott Reelected

Douglas E. Scott, M.D., Lexington, has been reelected treasurer of the Southeastern section, American Urological Association. He was chosen during the 27th annual session of the association in Nassau in April. Doctor Scott is trustee for the 10th KSMA district, as well as chairman of the Budget Committee.

Ben R. Brewer to Head Hospital Association

Ben R. Brewer, administrator of Western Baptist Hospital in Paducah, was named president-elect of the Kentucky Hospital Association at the April 4 session of the association in Louisville. Mr. Brewer will take office next year, replacing Otis L. Wheeler, administrator of Louisville Jewish Hospital, this year's president.

Mr. Brewer

Mr. Brewer is a native of Huntington, Tennessee, and received his BS degree at Memphis State University in 1951. He holds an MHA degree from Washington University in St. Louis, and served a residency in administration at Baptist Memorial Hospital in Memphis.

Before coming to Western Baptist Hospital in 1958, Mr. Brewer served as assistant administrator at Georgia Baptist Hospital in Atlanta. He has been president of the West Kentucky Hospital Conference and a trustee of the Kentucky Hospital Association, in addition to various committee memberships within the KHA.

E. W. Horgen, administrator of King's Daughters Hospital, Ashland, was reelected treasurer of the association, and Mrs. Charles W. Harting, Kevil, was reappointed state leader of the hospital auxiliary.

Elected to the KHA board of trustees were Sister Dorothy Maria, SS. Mary and Elizabeth Hospital, Louisville; Paul Ahlstedt, Methodist Evangelical Hospital, Louisville; Burnice Ransdell, State Tuberculosis Hospital, London, and W. Leon Hisle, Berea College Hospital, Berea. Hasty W. Riddle is executive director.

Medical Assistants to Meet May 18-19 in Louisville

The Kentucky State Association of Medical Assistants will hold its first meeting on May 18 and 19 at the Kentucky Hotel in Louisville. "Progress Through Education" will be the theme of the two-day session, which begins with registration at 10 a.m. Saturday, May 18.

Saturday's program will consist of an educational seminar on such subjects as the value of Medical Assistants' groups, personality development, insurance discussion, "Are you a Liability to your Doctor?", "External Cardiac Massage" and "Help in Kentucky for the Medical Indigent", to be followed by a skit. Cocktails, a banquet and the reception for the president elect will follow in the evening. After Sunday registration and breakfast, the group will hold its business meeting and election of officers. Installation of officers will take place at the state luncheon, to precede an afternoon board meeting.

Registration forms will be mailed to all members of the KSMA. All Medical assistants are urged to attend this important meeting.

Doctors Fortune and Overstreet

Doctor Overstreet Retires As ACP Governor

Sam A. Overstreet, M.D., Louisville, who has been governor of the Kentucky Chapter, American College of Physicians, for the past nine years, has retired from that office, and has been replaced by Carl H. Fortune, M.D., Lexington. Doctor Fortune was named at the April 4 session of the ACP in Denver.

Doctor Fortune is a 1926 graduate of the University of Michigan School of Medicine. He has served as a delegate to the KSMA from Fayette County, and has held various committee appointments in KSMA. He is active in the Fayette County Medical Society.

Doctor Overstreet has been editor of the Journal of the KSMA since 1958, and was Centennial president of KSMA. He has also served as Speaker of the KSMA House of Delegates.

Thomas M. Durant, M.D., Philadelphia, was chosen president-elect of the ACP at the Denver conference. He will take office in 1964. Wesley W. Spink, M.D., Professor of Medicine at the University of Minnesota Medical School, Minneapolis, was installed as new president of the College of Physicians.

Pathologists Schedule Regional At Lexington, June 7-8

The Great Lakes Region of the College of American Pathologists will meet in conjunction with the Kentucky Society of Pathologists at the University of Kentucky College of Medicine at Lexington June 7-8. Kentucky is the southern most member of the Great Lakes Region of the College and this is the first time a regional meeting has been held in this State. Pathologists from the Region and from adjacent states are expected to attend.

Among Kentucky physicians who will participate in the program are: William R. Willard, M.D., dean of the U. of K. College of Medicine; Rudolph J. Muelling, Jr., M.D., U. of K.; Marvin Murray, M.D., University of Louisville School of Medicine; Daniel L. Weiss, M.D., U. of K.; Ryland P. Byrd, M.D., U. of L.; Duane N. Tweeddale, M.D., Madisonville; Edward J. Fadell, M.D., Louisville; James T. Packer, M.D., U. of K.; Wellington B. Stewart, M.D., U. of K.; J. T. McClellan, M.D., Lexington; Albert Balows, Ph.D., Lexington; Elon T. Tucker, Lt. Col., U.S.A. (Ret.), U. of K.; Malcolm Barnes, M.D., Louisville.

President of the Kentucky Society of Pathologists is A. J. Miller, M.D., Louisville. H. Davis Chipps, M.D., Lexington, is program chairman.

Medical-Dental Building Dedicated April 7

The dedication on April 7 of the University of Louisville's new $3,400,000 Medical-Dental Research Building climaxed nearly a decade of community-wide planning and work. It marked the first major step in an envisioned three-part program to modernize and expand the University's medical and dental schools.

Albert B. Sabin, M.D., famed developer of the oral polio vaccine, called the dedication "a celebration of achievement for Louisville". Doctor Sabin was the principal speaker on the dedication day program. He is a distinguished-service professor of research-pediatrics at the Children's Hospital Research Foundation, University of Cincinnati.

The construction of a medical-dental instructional building and library is the second major goal of the building program, according to Henry Offutt, chairman of the U. of L. Board of Trustees. It is hoped that the structure will be under way within five years. A university hospital is in the planning stages. All of the proposed facilities will be included in the Medical Center near downtown Louisville.

The research unit has 120,000 square feet of floor space. A wide range of research projects—cancer, heart, pediatrics, and others—are already under way. Half of the funds for the building came from the National Institutes of Health. The remainder was raised by a University of Louisville Fund Drive.

Doctor Long in AMA Post

Robert C. Long, M.D., Louisville, Senior delegate to the AMA from KSMA, will serve as chairman of the important Reference Committee on Legislation and Public Relations of the AMA House of Delegates at the association's annual session in Atlantic City, starting June 16.

Representing the KSMA at the Atlantic City meeting of the House in addition to Doctor Long will be J. Vernon Pace, M.D., Paducah, and Wyatt Norvell, M.D., New Castle. Alternate delegates from KSMA are John C. Quertermous, M.D., Murray; J. Thomas Giannini, M.D., Louisville, and Carl C. Cooper, Jr., M.D., Bedford.

Doctor Limper Promoted

Margaret A. Limper, M.D., Louisville pediatrician, was recently named acting medical director of the Commission for Handicapped Children. Doctor Limper succeeds Marjorie K. Smith, M.D., who resigned to take a post with the New York City Bureau of School Health. Since last November Doctor Limper has been a full-time pediatric consultant with the Commission. She is a graduate of the University of Louisville School of Medicine and took pediatrics training at Children's Hospital in San Francisco and at General and Children's hospitals in Louisville. Before joining the Commission Doctor Limper was in private practice.

Doctor Coomer Will Head Dental Association

R. Burke Coomer, D.D.S., Louisville orthodontist, was named president-elect of the Kentucky Dental Association at the 103rd annual session of the association held in April at the Brown Hotel in Louisville. Doctor Coomer will take office in 1964.

Doctor Coomer

A native of Madison County, Doctor Coomer is the son of a rural physician, and a 1923 graduate of Berea Academy. He graduated from the University of Louisville School of Dentistry in 1927, and did post graduate work at the Dewey School of Orthodontia in New York and at the University of Detroit, Emory University, and Northwestern. He is an instructor in orthodontics at the University of Louisville.

In another action of the same session, the KDA announced the formation of a nonprofit insurance corporation to provide prepaid dental care for the first time in the state. It will be known as the Kentucky Dental Service Corporation, and will be similar to the Blue Cross-Blue Shield Plan of Kentucky.

Two types of policies will be offered. The "basic-care policy" will provide for emergency and preventative dental care. The "comprehensive" policy will cover all phases of dentistry including such specialties as oral surgery and orthodontics.

A schedule for premium costs has not yet been set. This is under study at the present time.

AAGP Elects Kentuckians

Charles G. Bryant, M.D., Louisville, was elected to the board of directors of the American Academy of General Practice at the academy's annual meeting in Chicago April 1. Doctor Bryant is past president of the Kentucky Academy of General Practice and is vice president of the Jefferson County Medical Society.

Carroll L. Witten, M.D., Louisville, was reelected speaker and a member of the board of directors. Doctor Witten and Doctor Bryant are graduates of the University of Louisville School of Medicine.

SMA Session Set for Nov.

The 57th annual session of the Southern Medical Association will be held November 18-21 in New Orleans, according to an announcement by the SMA. The four day scientific meeting will feature 48 half-day sessions of 21 medical specialty programs, a symposium on the thermal technics in medicine, a symposium on malignancies, a two-part program for science writers, eight closed-circuit color television programs and scientific and technical exhibits.

KPHA Names Doctor Brown President-Elect

B. F. Brown, M.D., Frankfort, was named president-elect of the Kentucky Public Health Association at the final session of the 15th annual meeting at the Kentucky Hotel in Louisville. Doctor Brown, director of the State Department of Health laboratory in Frankfort, will take office in 1962, succeeding Nick G. Johnson.

Doctor Brown, a 1953 graduate of the University of Louisville School of Medicine, practiced medicine in Harrodsburg and was health officer for Hancock, Daviess, and McLean counties until 1960. He was named director of the state laboratory in July, 1960.

In a separate action of the session, the Louisville and Jefferson County Sabin Oral Sunday steering committee was cited as the organization which contributed most to Kentucky public health in 1962. William P. VonderHaar, M.D., and Tevis Bennett, cochairmen of the committee, accepted the award. Other members of the committee were Kenneth P. Crawford, M.D., Robert L. McClendon, M.D., Thomas S. Wallace, Jr., M.D., Virginia Keeney, M.D., Eugene P. Stuart, M.D., James E. Metzler, M.D., Benjamin R. McPherson, M.D., Kenneth D. Thompson, M.D., and Calvin D. Anderson, M.D.

The steering committee supervised the mass polio-immunization campaigns in October, November, and February sponsored by the Jefferson County Medical Society and the Louisville Junior Chamber of Commerce.

Other officers of KPHA elected during the April meeting were: Joella Sisler, vice president; and L. Genrose DeSimmone, M.D., and Virginia Durrett, new board directors.

New KSMA Members Listed

New members of the KSMA are Ralph O. Roth, M.D., Rex Duff, M.D., John W. Harrison, M.D., Gerald B. Reams, M.D., and James F. Williamson, M.D., all of Ashland; George R. Bellamy, M.D., West Liberty; William J. Graul, M.D., Versailles; John C. Hagan, M.D., North Middletown; and Sam H. Reid, M.D., Danville.

Additional new members are: James F. Siles, M.D., Covington; Lowell Martin, M.D., Hueysville; Joseph C. Stiles, M.D., Owensboro; S. E. Coffman, M.D., W. R. Jernigan, M.D., and Vernon H. Fitchett, M.D., all of Madisonville. David Collins, M.D., Cavit Ozlu, M.D., Donald Potts, M.D., and Waldo Williams, M.D., are new members from Louisville. Others are Albert Lewis, M.D., Glasgow; William J. Kernohan, M.D., Hopkinsville; R. H. Rucker, M.D., Paducah; John H. Marchand, M.D., Henderson; John A. Logan, M.D., Sebree; and John Marsh, M.D., Tompkinsville.

Ky. Hospitals Accredited

The Joint Commission on Accreditation of Hospitals, Kenneth B. Babcock, M.D., Director, recently announced the accreditation of 66 Kentucky hospitals as of December 31, 1962. This figure compares with 67 in 1960, and 63 hospitals in 1958.

David M. Cox, M.D., Louisville, president of the Kentucky State Medical Association, addresses the ninth annual Senior Day gathering March 18 at the Medical Arts Building, Louisville.

Ninth Annual Senior Day Held March 18

Some 300 Jefferson County Medical Society members and seniors from the University of Louisville School of Medicine heard a humorous address given by Jim Comstock, editor of the West Virginia Hillbilly newspaper, Richwood, W. Va., at the close of the Ninth Annual Senior Day, March 18. Mr. Comstock, spoke satirically on such subjects as "The Sex Life of the Richwood, West Virginia, Female," and "How to Take Out Your Own Appendix."

The day's program began with a speech by David M. Cox, M.D., president of KSMA, who spoke to the 85 senior students on "Individual Doctor—Organized Medicine; Benefits and Responsibilities of Each," at the Rankin Amphitheatre in General Hospital.

Practical insight into medical practice was given the students by members of KSMA at the afternoon session held at the Medical Arts Building. Wyatt Norvell, M.D., New Castle, acted as moderator of the day-long program in the absence of Donald Chatham, M.D., Shelbyville, Chairman of the KSMA Senior Day Program, who was unable to attend because of illness.

The Senior Day Program is sponsored annually by the Kentucky State Medical Association in cooperation with the University of Louisville School of Medicine and the Jefferson County Medical Society.

Ky. Training Home Renamed

The Kentucky Training Home in Frankfort has been renamed the Frankfort State Hospital and School by executive order of Governor Bert Combs. L. F. Boland, M.D., is superintendent of the 1,018-bed institution for the mentally retarded. The institution was opened in 1860 as the Kentucky Institute for Feeble-Minded Children. It was designated Kentucky Training Home in 1945.

"Human Equation in Medical Practice" was one of two panels presented at the annual Senior Day at the University of Louisville March 18. Pictured are, left to right, panelists John M. Baird, M.D., Danville; Wyatt Norvell, M.D., moderator, New Castle; Durrett C. Bennett, M.D., Owensboro; and Orson P. Smith, Jr., M.D., Louisville.

Poison Control Meet May 22

Joint sessions of the second annual Kentucky Conference on Poisons and Poison Control and the first Kentucky Conference on Environmental Toxicology and Occupational Hygiene are slated for May 22-23 at the Kentucky Hotel in Louisville. The conferences are being sponsored by the executive committee of the Kentucky Poison Control Program in cooperation with the State Department of Health.

Registration for the session will begin at 7:30 p.m., EST, on May 21. Information concerning registration may be obtained by writing to Mr. Victor B. Fuqua, Secretary, Kentucky Poison Control Program, State Department of Health, 274 East Main Street, Frankfort, Kentucky. Accompany registration applications with a check for $5, a fee which covers costs of the dinner and registration for either or both conferences. See April Journal of the KSMA for program details.

Heredity Topic of Conference

The role of heredity in human behavior was the subject of the April 15-17 session in Lousville sponsored by the University of Louisville School of Medicine. Steven G. Vanderberg, M.D., professor of child development at the School of Medicine, was coordinator of the conference.

International authorities on genetics research attended the three-day meeting at the Sheraton Hotel. The session was sponsored by the University in conjunction with the United States Department of Health, Education, and Welfare. Guest speakers at the conference were Raymond B. Cattell, director of the laboratory of personality assessment and group behavior at the University of Illinois, and Ruth Guttman, M.D., of the Israel Institute of Applied Social Research in Jerusalem.

Bellarmine Holds Seminar For Physicians

A seminar for physicians was held at Bellarmine College in Louisville on April 20. It was the first of a series directed toward keeping professional people in the area abreast of current social problems.

John H. Ford, chairman of the philosophy department at Bellarmine, is the director of the seminars. Aiding in the April 20 program were Jack Mulligan, M.D., Louis Foltz, M.D., Richard Roth, M.D., and J. Duffy Hancock, M.D., all of Louisville.

Speakers for the session were Edmund D. Pellegrino, M.D., chairman of the department of medicine, University of Kentucky; Herbert Ratner, M.D., department of public health at Loyola University School of Medicine, and Daniel L. Sexton, M.D., president of the Southern Medical Association.

'Mi Casa Es Su Casa' In Kentucky*

By Mrs. Jo Rich

Three Cuban physicians working with the Kentucky State Board of Health and living in exile with their families in Frankfort are learning that Kentuckians speak Spanish with the *heart*. For the Franklin County auxiliary literally translates *my house is your house* by providing temporary financial aid, lessons from an English teacher, and sympathetic counsel and guidance to smooth countless bewildering aspects of life in a strange land.

The 23 auxiliary ambassadors of good will have discovered, also, that understanding is a two-way street involving some citizen education between their wards and the butcher, the baker, and the candlestick maker—for the exile's problems were compounded by the commonwealth's employee processing regulation that delays a first paycheck for 90 days.

Few American physicians' families have ever faced the plight of the more than 1,400 Cuban physicians who have brought their families to temporary refuge in a land they call the soil of freedom. These families have traded all worldly possessions to their robber government for plane tickets to Miami. But if they come impoverished—only one small suitcase each is permitted—they bring abundant courage and educational skills.

Mi casa es su casa in Kentucky was a spontaneous response to need within the kinship of the medical profession.

**Reprinted from the AMA Woman's Auxiliary Bulletin*

Digest of the Minutes of the KSMA Board of Trustees Meeting

March 6, 1963

FOLLOWING a report of the President which showed an intense amount of activity since the December 13 meeting of the Board and a report of the Headquarters Office, the Board replaced vacancies that existed on certain KSMA committees.

It voted to officially express to the American College of Obstetrics and Gynecology its appreciation for a $250 gift to the McDowell Home.

It was explained that two of the terms of appointees on the State Board of Health from the KSMA expired on December 31, 1962, and due to an oversight were not considered at the December 13 meeting of the Board. It was pointed out that the terms of E. M. Howard, M.D., Chairman of the Board, and Fred Moberly, M.D., Lexington, had expired.

The Board refused to accept a recommendation that it rescind a policy established some eight years ago by the Board (then known as the Council) that the Association would not nominate the same man for a position on the Board for more than two consecutive terms. It was pointed out that this policy was again considered in 1960 and was interpreted to mean that it would not be put into effect until all members of the Board nominated by KSMA might have an opportunity to serve two more terms after appointment by the Governor.

It was explained that for each M.D. opening on the Board of Health the law provided that KSMA should nominate three physicians from which the Governor would appoint one. The Board then proceeded to nominate for the position now held by Doctor Howard: George P. Archer, M.D., Prestonsburg, C. Dana Snyder, M.D., Hazard, and Clyde C. Sparks, M.D., Ashland; for the position now held by Doctor Moberly: Sam A. Overstreet, M.D., Louisville, David M. Cox, M.D., Louisville, and Daniel Costigan, M.D., Louisville.

The Board then considered certain recommendations from the KSMA Councils. From the KSMA Advisory Commission through the Council on Medical Services the following recommendations were presented:

1. That the Kentucky Blue Shield Plan report to the House of Delegates on the progress of the Senior Citizens Program for the calendar year each year, rather than from April to April as was suggested at a special meeting of the House of Delegates in 1962. It was taken by consent that this be done.

2. The next recommendation from the Blue Shield Advisory Commission related to the composition of the Board of Directors of Kentucky Physicians Mutual, which is the Blue Shield Plan for Kentucky, that it be recommended to the proper authorities that a reasonable balance of representation of the various physician specialties be placed on the Board of Directors of Kentucky Physicians Mutual. This motion carried.

3. After hearing a recommendation from the Advisory Commission relative to the establishment of the Insurance Review Board, there was considerable discussion among the members. It was stated that the purpose of the proposed board would be not only to help adjudicate alleged abuses on the part of physicians working for third parties, but would give physicians who felt aggrieved by third parties a voice in the recommendations made to third parties. After discussion, the Board approved the idea in principle and authorized the Commission to bring in a specific proposal for the next meeting of the Board.

4. The final recommendation of the Advisory Commission related to a special proposed four-page Blue Shield insert into The Journal of KSMA. Such matters as implementing the Senior Citizens Program, adjudicating claims, and other related problems would be handled. Cost of the insert would be born by the Blue Shield. It was also indicated that the Health Insurance Council would be given the same opportunity to have this four-page insert if desired. The Board approved the recommendation.

Another recommendation from the Council on Medical Service came from the Mental Health Committee. It was requested that the AMA program for mental health be approved, that it be brought to the attention of the KSMA membership, and that our own Association enter into long-range planning program for Kentucky. After brief discussion, the recommendation was approved.

A recommendation from the Council on Communications and Public Service relating to participation in a research program on fatal highway collisions was made and approved.

The Board voted to send the Chairman of the KSMA Committee on Aging to the Third National Conference to Improve Health Care of the Aged in San Francisco, May 2-4.

A report from the Chief of the Audit Division of the Louisville office of the Internal Revenue Bureau stated that KSMA members paying their own way to the Congressional Dinner in Washington could not deduct the expense from their income tax.

The Board then heard reports of the various Trustee District Grievance Committees and acted on them.

During the dinner session of the Board one of the Interim Meeting speakers for the meeting the next day from Dallas, Texas, was introduced and spoke briefly. Due to the lateness of the hour, it was decided that unfinished items on the agenda should be carried over to the next meeting of the Board scheduled for Thursday, June 6, in Louisville.

Sustained high-level protection in peptic ulcer

all day

all night

with b. i. d. dosage

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Brand of PROPANTHELINE Bromide

Prolonged-Acting Tablets—30 mg.

Pro-Banthīne P. A. provides the full anticholinergic benefit of Pro-Banthīne® plus the greater convenience and more consistent therapeutic effect of a long-acting dosage form.

Asher[1] has summarized the advantages of prolonged-action dosage forms: "First, they should be of great value in the suppression of night acid secretion in the ulcer patient. Also, in the ulcer patient, with high acid secretion during the day these drugs should be of help when used with regular doses of shorter-acting anticholinergic agents. A third application is in the chronic treatment of certain patients whose tendency to recurrent ulcer has been established."

Pro-Banthīne P.A. offers consistent, sustained anticholinergic effects for more consistent suppression of acid secretion and motility on simple twice or thrice daily dosage in most patients.

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Research in the Service of Medicine

Suggested Adult Dosage:
One tablet at bedtime and one in the morning, supplemented, if necessary, by additional tablets of Pro-Banthīne P.A. or standard Pro-Banthīne to meet individual requirements.

Pro-Banthīne P.A.
is supplied as capsule-shaped, peach-colored tablets of 30 mg. each.

Contraindications:
Glaucoma; severe cardiac disease.

Possible Side Actions:
Xerostomia, mydriasis and, occasionally, hesitancy in urination. Theoretically, a curare-like action may occur.

1. Asher, L. M.: The Choice of Anticholinergic Drugs in the Treatment of Functional Digestive Diseases, Amer. J. Dig. Dis. 4:260-275 (April) 1959.

MEDICAL SCHOOL NEWS

Doctor Haller Resigns From U. of L. Faculty

J. Alex Haller, Jr., M.D., chief of pediatric-surgery at the University of Louisville, has resigned to rejoin the faculty of Johns Hopkins University School of Medicine in Baltimore. He is also head of the university's open-heart surgery program at Children's Hospital in Louisville.

Doctor Haller

Doctor Haller, a graduate of John Hopkins, came to U. of L. in 1959 as an instructor in surgery and a Price Fellow in cardiovascular research. He will return to John Hopkins as associate professor of surgery.

Damel Stowens, M.D., Louisville pathologist, was appointed April, 15 as a deputy coroner by William M. Petty, M.D. Doctor Stowens is director of laboratories at Children's Hospital and associate professor of pathology at the University of Louisville School of Medicine.

Doctor Stowens will serve as deputy coroner without pay in order to further his studies of the causes of children's deaths.

Grants For Research

The American Heart Association recently announced the award of basic medical-research grants totaling $60,000 to five U. of L. School of Medicine scientists. Thomas G. Scharff, Ph.D., assistant professor of pharmacology, received a new five-year established-inventor grant to carry out basic studies on sugar and potassium ion transport.

Receiving continued established-inventor grants were Gasper Carrasquer, M.D., Duncan Dallum, Ph.D., and Agamemnon Despopoulos, M.D. Nestor J. Carlisky, M.D., received a continued research-fellow grant.

A grant of $13,459 is being made available to the School of Medicine to demonstrate to the community the effectiveness of early cancer detection. The grant is given by the Division of Chronic Diseases, Public Health Service, of the U.S. Department of Health, Education, and Welfare.

Herbert E. Brizel, M.D., assistant professor of radiology at the U. of L. School of Medicine, has received a three-year $24,000 advanced clinical fellowship from the American Cancer Society.

Other Gifts and Grants

The School of Medicine has also received grants for the following projects: $1,000 from Smith, Kline and French Laboratories for a symposium April 19 and 20 to commemorate the 50th anniversary of the Louisville Child Guidance Clinic; $200 from James W. Markham, M.D., for a special research fund; and $240 from various donors for lukemia research.

Other U. of L. Appointments

The University recently announced the additional appointments of William H. McBeath, M.D., lecturer in community health; Elias H. Chacalos, Ph.D., instructor in physiology; Presley F. Martin, M.D., instructor in psychiatry; and Manuel Schwartz, Ph.D., associate in physiology.

Faculty Appointments Announced by U.K.

The University of Kentucky College of Medicine recently announced the appointment of five new full-time faculty members and two voluntary faculty members.

John L. Duhring, M.D., has been named assistant professor, department of Obstetrics and Gynecology. Doctor Duhring is a graduate of the University of Pennsylvania College of Medicine. Ernesto A. Fonts, M.D., a graduate of the University of Havana School of Medicine, was named instructor, department of Radiology.

Richard P. Harbord, M.D., new assistant professor, department of Anesthesiology, is a graduate of Liverpool College in Lancashire, England. Joseph C. J. Finney, M.D., Ph.D., associate professor, department of Psychiatry, is a graduate of Harvard University Medical School and of Stanford University. Frida G. Surawicz, M.D., instructor, department of Psychiatry, is a graduate of the University of Amsterdam and the University of Munich.

Voluntary faculty members at the College of Medicine will be Herbert B. Hudnut, M.D., Morehead, and Francis Bennett Wells, M.D., Lexington. Doctor Hudnut, a graduate of Harvard University Medical School, will be an assistant professor in the department of Clinical Medicine, and Doctor Wells will become an instructor in the department of Clinical Surgery. Doctor Wells is a graduate of the University of Louisville School of Medicine.

Felix G. Fleischner, clinical professor emeritus of Radiology, Harvard Medical School, will be a visiting professor of Radiology at U.K. from May 8 to 11, 1963.

Two in Ky. Receive Scholarships

James A. Cunningham, Lexington, University of Kentucky College of Medicine, Lexington, and Gerald E. Vanderpool, Louisville, University of Louisville School of Medicine, were among the 10 medical students to receive Sears-Roebuck Foundation Preceptorship Scholarships for 1963, according to an announcement by Russell Staudacher, executive secretary of the Student American Medical Association, which co-sponsors the program.

Mr. Cunningham will work with Ernest Blease, Jr., M.D., Springfield, Col., from June 10 to August 10. Mr. Vanderpool will work with Jack D. Bland, M.D., Holland, Ind., from July 1 to September 1.

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In a comprehensive range of indications marked by moderate to moderately severe pain, PERCODAN assures speed, duration, and depth of analgesia by the oral route...acts within 5 to 15 minutes...usually provides uninterrupted relief for 6 hours or longer with just 1 tablet...rarely causes constipation.

Formula—Each scored yellow PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl (Warning: May be habit-forming), 0.38 dihydrohydroxycodeinone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. acetophenetidin, and 32 mg. caffeine. **Also available:** PERCODAN®-DEMI, containing the complete PERCODAN formula but with only half the amount of salts of dihydrohydroxycodeinone and homatropine. Both products are on oral Rx in all states where laws permit. **Average Adult Dose**—1 tablet every 6 hours. **Side Effects and Contraindications**—Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to acetylsalicylic acid or acetophenetidin and in those with blood dyscrasias. *Literature on request.* **ENDO LABORATORIES Richmond Hill 18, New York**

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Joseph R. Miller, M.D., Benton, vice-president of the KSMA, is shown at the right in the photograph taken during the annual banquet of the Missouri State Medical Association, held March 26 at the Hotel Muehlebach in Kansas City. Doctor Miller attended the meeting as the representative of David M. Cox M.D., president of the KSMA. Shown with Doctor Miller are Donald M. Dowell, M.D., center, president of the MSMA, and George F. Lull, M.D. president of the Illinois State Medical Association.

Ky. Surgeons Elect

William T. Rumage, M.D., Louisville, was elected president of the Kentucky Chapter of the American College of Surgeons at the annual meeting March 29-30 in Louisville. Doctor Rumage succeeds Clyde C. Sparks, M.D., Ashland.

Other officers elected were: R. W. Robertson, M.D., Paducah, vice-president; Laurence Quill, M.D., Newport, treasurer; Richard F. Grise, M.D., Bowling Green, Robert Pennington, M.D., London, and J. Vernon Pace, M.D., Paducah, councilors. R. J. Noer, M.D., Louisville, was named governor.

Mental Health Posts Filled

William J. Kernohan, M.D., will replace R. R. Knowles, M.D., as superintendent of Kentucky State Hospital at Danville, according to a recent announcement by Harold L. McPheeters, M.D., commissioner of the State Department of Mental Health. A native of Ireland, Doctor Kernohan is a graduate of Queen's University in Belfast, and holds a psychological medicine diploma from Ireland's Royal College of Physicians and Surgeons. He has served as clinical director at Western State Hospital in Hopkinsville for the past year.

Doctor McPheeters also stated that Thomas F. Burke, M.D., has been named superintendent of Outwood State Hospital and School at Dawson Springs, replacing Ewen Fraser, M.D. Doctor Burke is a graduate of the Royal College of Physicians and Surgeons in London.

Attend Blue Shield Meet

William H. Cartmell, M.D., Maysville, president of Kentucky Physicians Mutual, Inc. (The Blue Shield Plan for Kentucky), was the delegate from Kentucky at the annual business meeting of the National Association of Blue Shield Plans, held March 31-April 1 in Chicago.

At the same meeting H. Thomas McGuire, M.D., New Castle, Del., assumed the office of president of the national association. Also attending from Kentucky were W. Vinson Pierce, M.D., Covington, member of the AMA Insurance Committee, with D. Lane Tynes, executive director of Blue Cross-Blue Shield in Kentucky, and J. Ed McConnell, vice-president of external affairs. Both are from Louisville.

Social Security Promotion

Hugh A. McNary, for ten years district manager for the Social Security Administration in Louisville, has been promoted to manager of Social Security operations in Puerto Rico and the Virgin Islands, it was announced recently by the U.S. Dept. of Health, Education, and Welfare.

Mr. McNary and the KSMA have cooperated many times in carrying out certain programs under Social Security.

Industrial Medical Assn. Elects

New officers of the Kentucky Industrial Medical Association were elected at the April meeting in Louisville. Frederick P. Shepherd, M.D., Louisville, was elected president, succeeding Charles Allen, M.D., Louisville. Other officers are: Arthur J. Shulthise, M.D., Louisville, president-elect; William P. Wharton, M.D., Lexington, vice-president; and John Eckerle, M.D., Louisville, secretary-treasurer. Directors for the 1963-65 term are William P. VonderHaar, M.D., Louisville; William J. Colburn, M.D., Calvert City; and Tom J. Smith, M.D., also of Louisville.

Wendell R. Kingsolver, M.D., of Carlisle, Kentucky, has arrived with his family in the Republic of Congo, where he will practice under the auspices of the "Operation Doctor" program of the Congo Protestant Relief Agency. Doctor Kingsolver will serve for five months at the American Baptist Foreign Mission Society hospital at Kikongo, 125 miles from Leopoldville. He is a 1952 graduate of the University of Michigan School of Medicine.

Miss Phyllis Knight, WHAS Home Director, has been awarded the McCall's Magazine Golden Mike Award for the second time. In 1958 Miss Knight was honored by McCall's for the first time as a result of her highly successful campaign to persuade thousands of Louisville women to take cervical cancer detection tests, resulting in early treatment for a significant number of cancer patients.

Is there a need for a purely bacteriostatic enteric compound?

— that would go straight to the basis of most intestinal infections.

— that could be employed in the treatment of non-specific ulcerative colitis.

— that would prepare the intestine for operation.

— that would reduce the number of E. Coli and Clostridia in the intestine.

If you agree that there is just such a need, then you'll appreciate the capabilities of:

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CAUTIONS AND SIDE EFFECTS:

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COMPOSITION:

Each tablet and each 5cc (Average teaspoonful) contains —

SUCCINYL-SULFATHIAZOLE . . 0.25 Gms.
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SUPPLIED:

INTESTOL tablets in bottles of 100 and 1,000
INTESTOL Suspension in pints only.

Another established need product

KSMA Council, Committee Reports

Hospital Committee

James B. Holloway, M.D., Chairman

Louisville **March 21, 1963**

The Hospital Committee met for its first time this year at the KSMA Headquarters on March 21, 1963. The committee discussed hospitals in three communities that appear to be having some problems. In one problem, which referred to charging for copies of medical records, the committee approved a motion that a charge of 50¢ a page for furnishing copies of medical records is a reasonable charge. A detailed discussion concerning the United Mine Workers Association Hospitals followed.

The chairman congratulated the Kentucky Hospital Association for an outstanding job in their publication of "A Guide For Release Of Information From Medical Records." The meeting adjourned following a general discussion on voluntary insurance coverage.

Council on Legislative Activities

John C. Quertermous, M.D., chairman, National Affairs
Robert D. Shepard, M.D., chairman, State Affairs

Louisville **April 10, 1963**

KSMA's Council on Legislative Activities and Legislative Committee met in the board room at Headquarters Office building April 10. A major portion of the business pertained to State legislative affairs and particularly the encroachment of chiropractor activities in the field of medicine. Plans are being studied by the Council and Committee on how to best inform the public and legislators that chiropractors are not trained to treat illnesses they claim they can treat.

Headquarters Office was directed to again contact county medical societies that have not submitted the names of the county legislative key men and ask that the names be submitted immediately. It was decided that sub-district legislative key men would not be appointed by KSMA's Board of Trustees until after the May Primary. Headquarters Office was requested to inform all legislative key men with the names of candidates who have filed for the Primary election and after the Primary send a second list indicating those who were nominated.

William R. Ramsey, Field Representative of the AMA, commented on "Operation Hometown" which is a program designed to aid county medical society members in their opposition to King-Anderson legislation.

Emergency Medical Services Committee

William T. Rumage, Jr., M.D., Chairman

Louisville **March 14, 1963**

The Emergency Medical Services Committee held its second meeting of the associational year at the KSMA Headquarters March 14, 1963. The committee discussed its participation in Kentucky's Task Force on Health Resources Committee, which is collecting data on Health Resources that would be available for use in case of a disaster. The chairman announced that Winfrey P. Blackburn, M.D., Frankfort, would serve on the Task Force as a representative of the Emergency Medical Services Committee.

It was reported that the Medical Self-Help Training Course will be presented to sophomore students at the University of Louisville Medical School. The State Health Department has received 300 Medical Self-Help kits and 175 have been distributed to the county level. The committee was informed that Kentucky was expected to receive 6-10 more 200 bed Emergency Hospitals to supplement the 27 hospitals now stored throughout the state.

The committee discussed a special issue of the KSMA Journal on "Emergency Medical Care in Disaster Planning" which is scheduled for September of this year.

School Health Committee

R. E. Davis, M.D., Chairman

Lexington **April 4, 1963**

The second meeting of the School Health Committee was held April 4, 1963, in Lexington.

The main item of business discussed was a review of last year's regional Athletic Injury Prevention conferences and plans for the conferences this year. As a means of securing greater audience participation, the committee tentatively made plans to hold the conferences in conjunction with the Kentucky High School Athletic Association's Football Rules clinics. The committee is planning to have conferences in Newport, Louisville, and Pineville during August, and Mayfield or Paducah during October.

The committee agreed that local doctors should participate on the panels when the conferences are held in their areas.

Final plans on these conferences will be made at the next meeting of the committee which is scheduled during June.

Public Health Committee

Delmas M. Clardy, M.D., Chairman

Louisville **March 28, 1963**

The Public Health Committee met March 28, 1963, at the Brown Hotel in Louisville. The members of the committee discussed the successful Oral Polio Vaccine Program in Kentucky and approved the drafting of a letter of appreciation to those who contributed to its success.

The committee unanimously endorsed May 5-11 as Immunization Week in Kentucky and appointed a sub-committee to plan the promotion.

Doctor Clardy reported that at this committee's recommendation, a scientific program on carcinoma of the lung would be presented at the 1963 KSMA

annual meeting. Following a presentation on venereal disease and venereal disease control, the committee went on record recommending that KSMA encourage all physicians to report all reactive serologies to the Kentucky State Department of Health.

In Memoriam

ORVILLE RAY MILLER
Louisville
1891-1963

Orville Ray Miller, M.D., 71, died recently after 49 years in the practice of orthopedic surgery in the Louisville area. He was a 1913 graduate of the Medical Department of the University of Louisville. Doctor Miller was on the staff of Children's Hospital and a consultant in orthopedics at St. Joseph Infirmary before his retirement a year ago.

R. HAYES DAVIS, M.D.
Louisville
1884-1963

R. Hayes Davis, M.D., 78, Louisville, Ky., internist, died March 27 at Norton Memorial Infirmary, Louisville, after a month's illness. Doctor Davis was graduated from the Medical Department of the University of Pennsylvania in 1906. He had practiced medicine at Louisville for 57 years.

EDWARD WILSON, M.D.
Pineville
1879-1963

Edward Wilson, M.D., 83, died after an illness of several months at Pineville, where he had been a general practicioner since 1904. Doctor Wilson graduated from the old Hospital College of Medicine, now a part of the University of Louisville. He is credited with the first abdominal surgery in Letcher County and the first Caesarean section in Bell County. He was a founder of Bell County's first hospital and was instrumental in the opening of Pineville Community Hospital in 1938.

Doctor Wilson was honored in 1953 at a celebration marking his 50th anniversary as a physician. He retired in 1958.

LUTHER E. NICHOLS
Princeton
1874-1963

Luther E. Nichols, M.D., 89, physician for many years at the former Veterans Hospital at Outwood, died March 28 at his home near Princeton. He was a 1903 graduate of the Hospital College of Medicine in Louisville. Doctor Nichols, a native of Caldwell County, practiced medicine in Dawson Springs before going to Outwood.

H. LOGAN GRAGG
Junction City
1884-1963

H. Logan Gragg, M.D., 79, a Junction City general practitioner for 52 years, died April 7 after a heart attack. A native of Carter County, Doctor Gragg was a 1911 graduate of Lincoln Memorial University, Knoxville, Tennessee. In 1955 he was honored with a "Doctor Gragg Day" celebration at Junction City.

CHARLES McGINNIS FRANCIS
Lexington
1918-1963

Charles McGinnis Francis, M.D., 44, died April 2 in Lexington after a short illness. Doctor Francis graduated from the University of Louisville School of Medicine in 1943. He was a clinical instructor in the Department of Surgery at the University of Kentucky College of Medicine, and was a member of the KSMA and AMA.

Student AMA

University of Kentucky

Ballard Wright Reelected President

The Student American Medical Association of the University of Kentucky recently elected officers for the year 1963-64. Ballard Wright, Prestonsburg, class of 1964, was reelected president.

Mr. Wright attended Berea College, where he held many student offices. He graduated in 1959 from Berea. Mr. Wright was appointed to the Air Force Senior Medical Student Program and will practice in Kentucky after his release from service.

Mrs. Shirley Moore, new vice president, served as secretary last year. She is from Jefferson County and graduated from the University of Kentucky on a National Science Foundation grant. Mrs. Moore received her master's degree from the Academic Year Institute at the University of Texas in 1958. Her husband, Robert, is a freshman at the University of Kentucky Dental School. Both plan to practice in Kentucky.

Norman R. Nedde of the 1966 graduating class was elected secretary. Mr. Nedde, a native of Pittsburgh, Pa., is a 1960 graduate of Northwestern University.

Gary R. Wallace, treasurer, is a member of the 1966 class. He is from Ashland, Ky. Mr. Wallace attended Georgetown College and graduated from the University of Kentucky with a B.S. in engineering. He was a member of Sigma Alpha Epsilon and Alpha Epsilon Delta.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1963 Annual Meeting — Kentucky State Medical Association

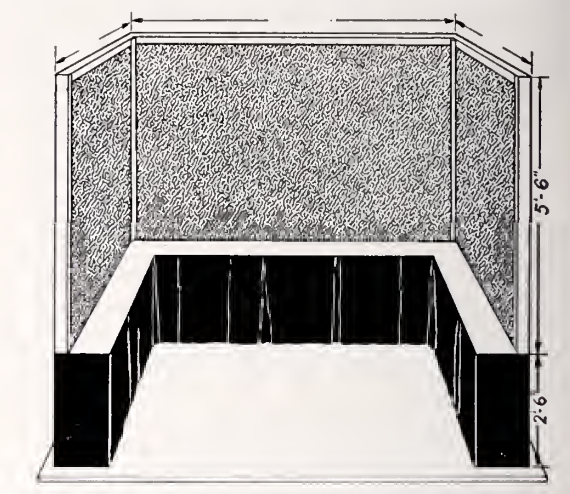
Phoenix Hotel — **Lexington, Kentucky** — **September 23, 24, 25, 26**

Fill Out and Mail to:

J. ALEX HALLER, M.D., Chairman
Committee on Scientific Exhibits
Department of Surgery
University of Louisville
511 S. Floyd Street
Louisville 2, Kentucky

Applications for space should be received before July 1, 1963

Dimensions and structure of KSMA Scientific booth are shown in accompanying illustration



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1. Title of Exhibit: ....

2. Name (s) of Exhibitor (s): ....

   ....

   Institution (if desired): ....

   Mailing Address ....

3. Do you have a built-in exhibit? ....

4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)

5. Exhibit will consist of the following: (Check which)

   Charts and Posters.... Photographs.... Drawings.... X-rays....

   Specimens.... Moulages.... Other Material..
   (Describe)

6. Booth Requirements:

   Amount of wall space needed? ....

   Back wall .... Side walls ....

   Square feet needed? ....

   Shelf desired? (yes or no) ....

7. Has This Exhibit Been Exhibited Before? (yes or no) ....

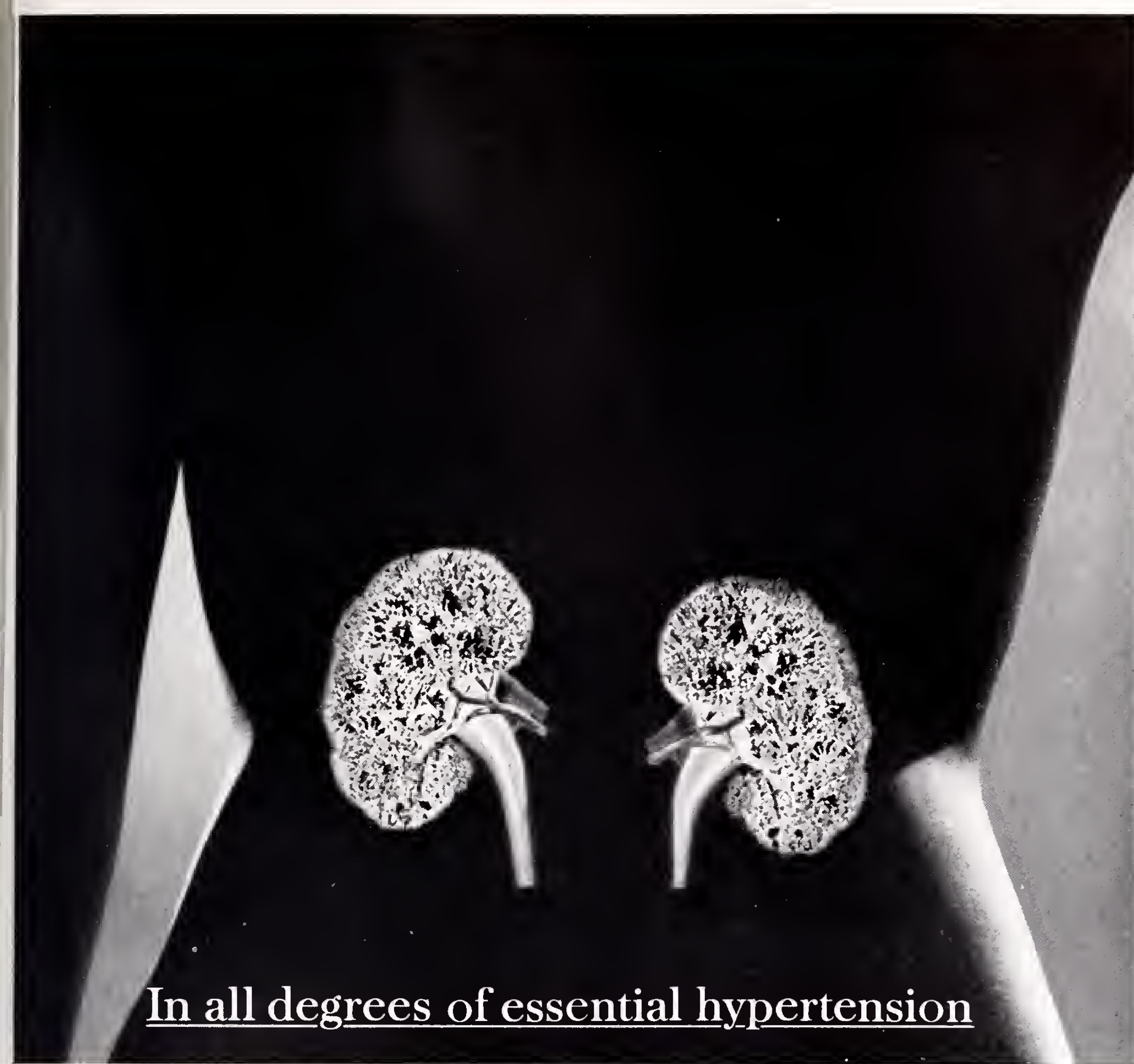
Date ....
Signature of Applicant

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KSMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.



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When treatment of hypertension is effective, the danger of damage to the renal system is reduced.[1,2] "Hypertensive patients suffer from vascular deterioration roughly proportional to the severity of the hypertension. ...Reduction of blood pressure to normotensive levels reduces or arrests the progress of vascular damage with a resultant decrease in morbidity and mortality. Among two comparable groups of patients with [nonmalignant] hypertension of equal severity, 72 per cent of those treated were still living after five years or more, while only 24 per cent of those not treated were alive at the end of this period."[1] *Because Rautrax-N lowers blood pressure so effectively, it will provide this important protection for your hypertensive patients.*

Rautrax-N—a combination of Raudixin, Squibb Standardized Rauwolfia Serpentina Whole Root, and the diuretic, Naturetin, Squibb Bendroflumethiazide—is effective in mild,[4] moderate[3,4] or severe hypertension.[3,5] It lowers blood pressure gently and gradually. And control of hypertension helps protect not only the kidneys but also the heart and brain from vascular damage.[2] For full information, see your Squibb Product Reference or Product Brief.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin, 4 mg. Naturetin, and 400 mg. potassium chloride. *Rautrax-N Modified*—capsule-shaped tablets providing 50 mg. Raudixin, 2 mg. Naturetin, and 400 mg. potassium chloride.

References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (4) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (5) Feldman, L. H.: North Carolina M. J. *23*:248 (June) 1962.

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Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

The University Surgery Day on "Surgical Physiology" scheduled for May 16 at the University of Kentucky Medical Center has been cancelled. The monthly surgical days are planned to be resumed in October. Please check the Continuing Educational Opportunities page of later issues of The Journal for exact dates. The Kentucky Surgical Society will meet at the University of Kentucky Medical Center on May 17-18.

In Kentucky

MAY

9-11 "Cardiology," University of Kentucky Medical Center, Lexington, Ky.

11-12 Kentucky Society of Anesthesiologists, Phoenix Hotel, Lexington, Ky.

15-16 Kentucky Pediatric Society and Kentucky Chapter, American Academy of Pediatrics, Lexington, Ky.

17-18 Kentucky Surgical Society, University of Kentucky Medical Center, Lexington, Ky.

22-23 Kentucky Pediatric Society, University of Kentucky Medical School, Lexington, Ky. (22nd: Respiratory Distress Syndrome; 23rd: Resuscitation of the Newborn)

22-23 Second Kentucky Conference on Poisons and Poison Control and First Kentucky Conference on Environmental Toxicology and Occupational Hygiene, Kentucky Hotel, Louisville, Ky.

JUNE

6 Harrodsburg Seminar, Kentucky Academy of General Practice, Beaumont Inn, Harrodsburg, Ky.

21-22 Kenlake Seminar, Kentucky Academy of General Practice, Kentucky Dam Village, Gilbertsville, Ky.

JULY

26-27 Park Seminar, Kentucky Academy of General Practice, Jenny Wiley State Park, Prestonsburg, Ky.

AUGUST

7 London Seminar, Kentucky Academy of General Practice, Sue Bennett College, London, Ky.

18 Bluegrass Symposium, Kentucky Academy of General Practice, Phoenix Hotel, Lexington, Ky.

28-29 Cave Area Seminar, Kentucky Academy of General Practice, Diamond Caverns Hotel, Park City, Ky.

SEPTEMBER

23-26 KSMA Annual Meeting, Phoenix Hotel, Lexington, Ky.

OCTOBER

10 Maysville Seminar, Kentucky Academy of General Practice, Mason City Health Building, Maysville, Ky.

18-20 Pediatrics Postgraduate Course, Children's Hospital, Louisville, Ky.

Surrounding States

MAY

13-15 American Gynecological Society, Roosevelt Hotel, New Orleans, La.

15 Medical Treatment of Malignancy, Indiana University Medical Center, Indianapolis, Ind.

16 Medical Problems in Renal Disease, Indiana University Medical Center, Indianapolis, Ind.

20-24 Cardiopulmonary Disease: American College of Physicians Course, Indiana University Medical Center, Indianapolis, Ind.

JUNE

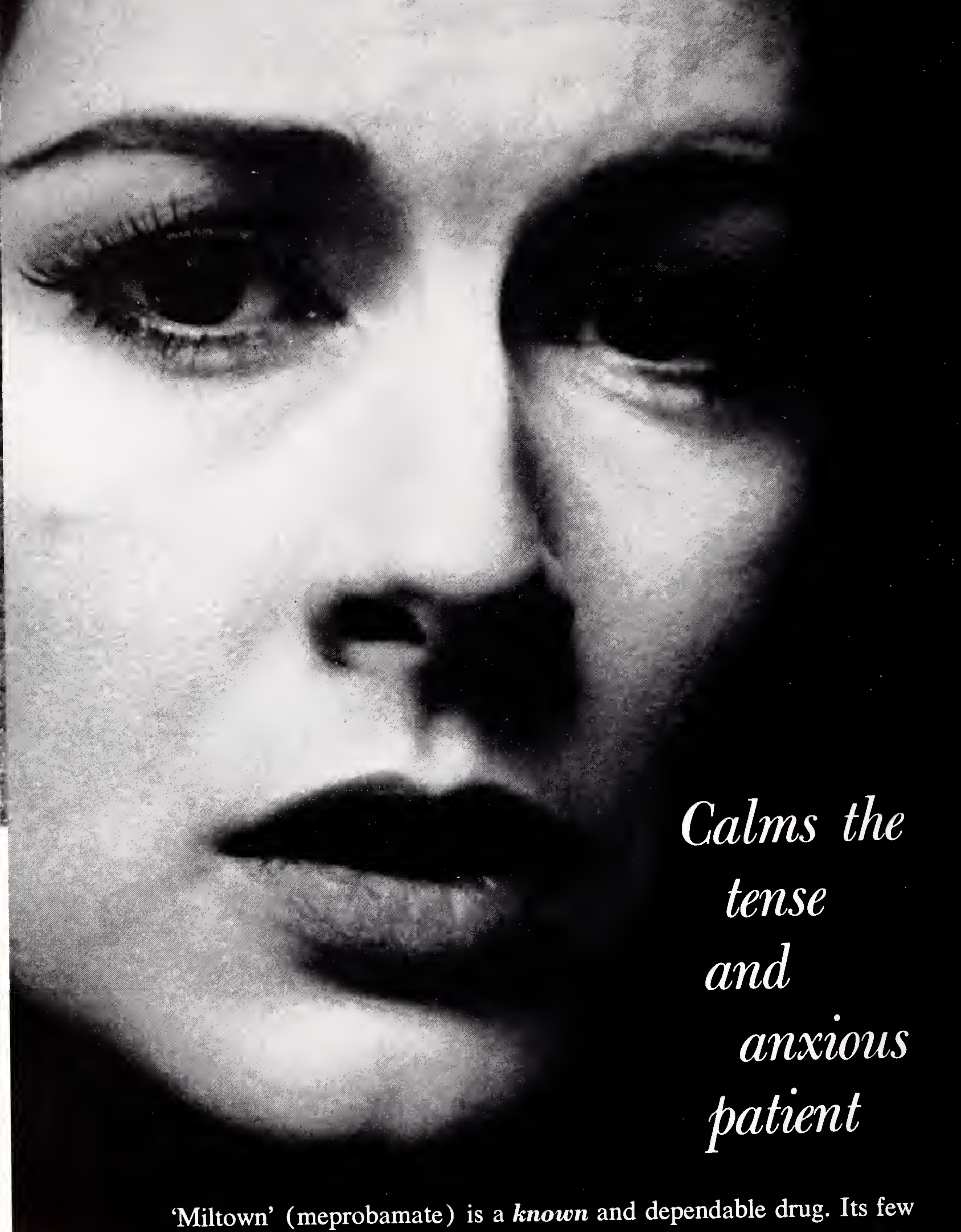
3-7 Internal Medicine: Current Physiological Concepts in Diagnosis and Treatment, American College of Physicians Course, Cincinnati General Hospital and University of Cincinnati College of Medicine, Cincinnati, Ohio.

13-17 American College of Chest Physicians, Ambassador Hotel, Atlantic City, N.J.

17-21 5th Annual refresher course in Diagnostic Roentgenology, University of Cincinnati College of Medicine, Cincinnati, Ohio.

16-20 Annual Meeting, American Medical Association, Auditorium & Convention Hall, Atlantic City, New Jersey

24-27 American Orthopaedic Association, The Homestead, Hot Springs, Va.



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Clinically Proven

in more than 750 published clinical studies and over eight years of clinical use

Outstanding Record of Effectiveness and Safety

1. Relieves anxiety and anxious depression in a broad spectrum of clinical conditions.
2. Doesn't leave patients "too groggy" to work or think or learn.
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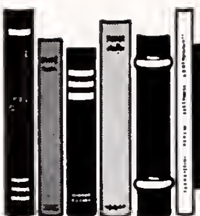

IN THE BOOKS

CORRELATIVE NEUROANATOMY AND FUNCTIONAL NEUROLOGY: (11th Edition) by Joseph G. Chusid, M.D., and Joseph J. McDonald, M.D.; published by Lange Medical Publications, Los Altos, California; pages, 384; price, $5.50.

The 11th edition of this volume by Doctors Chusid and McDonald continues to be an admirable condensation of neurology for students and non-neurological specialists.

In 384 pages the field of neurology and its allied sub-specialties have been systematically and concisely covered. It is oriented so that understanding of function and structure can be applied to the problems in everyday clinic neurology. Sections on electro-myography, electroencephalography, and neuroradiology, though necessarily sketchy, are worthwhile complements to the book.

The authors have compressed enormous quantities of data into comprehensible charts and diagrams sprinkled effectively throughout the volume.

There are abundant in-text references that have been kept up to date, and a selected text book reference is appended at the end.

This pithy, heavily-illustrated manual should continue its established reputation and usefulness to medical students, residents, and graduate physicians reviewing for specialty board examinations outside the field of Neurology.

Richard C. Turrell, M.D.

SYNOPSIS OF GENITOURINARY DISEASE: by Austin I. Dodson, Jr., M.D., and J. Edward Hill, M.D.; published by The C. V. Mosby Company, St. Louis, Missouri; pages, 384; price, $7.75.

This is the seventh edition of a urological textbook originally published in 1934. The most recent revision is not greatly changed from previous publications. It does, however, present a much more lucid table of contents and index than did the earlier editions, enhancing its value as a reference manual.

As the title suggests, this book presents merely a summary of the various genitourinary disorders. Emphasis is placed upon pathogenesis and diagnosis. Sections on treatment are concerned primarily with non-surgical management and there is no emphasis placed on surgical technique. The type surgery indicated is mentioned but is not described. Recent developments in the field of urology have generally been included in the revision, but certain subjects such as adreno-genital disorders, the problem of intersex hemodialysis, etc., are handled in a very superficial fashion.

Of particular interest to the general practitioner is the second chapter which deals with instruments, minor urological procedures and internal medications. In this section minor urological techniques, such as urethral instrumentation, minor surgical procedures and medical therapeutic measures which may be utilized in the office are described in some detail. This particular section emphasizes the various urological tools which should be available and utilized in the general practice of medicine. At the same time, it describes the limitations and hazards these procedures will entail. The illustrations and photographs are essentially those seen in previous volumes and amply illustrate the pathological lesions and therapeutic measures described in the text.

Controversial points are generally avoided in the book and where controversy does exist, only the author's viewpoint is expressed. This is in keeping with the general tone of the book which is to present basic information in a concise fashion. There is no bibliography.

This book, which is aimed at the medical student, intern and general practitioner, is instructive, readable and quite concise. It is a ready source of rudimentary information about most urological abnormalities with a particularly nice discussion of minor urological procedures and office techniques.

Lonnie W. Howerton, Jr., M.D.

SYNOPSIS OF ROENTGEN SIGNS: by Isadore Meschan, M.D., and R.M.F. Farrer-Meschan, M.D.; published by W. B. Saunders Company, Philadelphia; pages, 436; price, $11.

As indicated in their preface, the authors have produced a unique book; one which in effect is an illustrated outline of diagnostic Radiology. It summarizes a vast amount of information about roentgenologic findings in most of the common disorders. The book which results is ideal for the student of radiology as well as for medical students in general.

Doctor I. Mechan brings a notable experience in the writing of books on radiologic subjects to bear on the subject at hand. There is a concise and clear subdivision of subjects in related order. Tabulations of important clinical findings are placed with x-ray findings. Many of the conditions are illustrated diagramatically so that the important x-ray changes are clearly shown and rendered understandable to the uninitiated student. In a small space a great many variations in roentgen anatomy are clearly illustrated by what they refer to as "midget exhibits."

An interesting feature of the book is a question section at the end of each chapter. One is given the opportunity of testing his comprehension of the material covered. This is ideal for the student. The questions are stimulating and evoke much thought.

One would not turn to this book as a treatise on

the finer points of pathological anatomy and physiology. It is not intended for this purpose. Almost all pertinent information is included in an easily understood presentation. The book would be valuable to anyone who will ever produce a report of an x-ray examination and would probably also help many physicians who must interpret such reports.

Gerald M. Peterson, M.D.

Bulging Fontanel . . .

(Continued from Page 425)

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NATO Dependents' Care

On and after July 1, 1963, the accompanying dependents of active duty military personnel, who are members of the land, sea and air forces of North Atlantic Treaty Organization countries stationed or passing through this country, will be entitled to the same care under the Medicare Program (Office for Dependents' Medical Care) as those dependents of members of the uniformed services.

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The fifth annual refresher course in Diagnostic Roentgenology will be held June 17-21 by the Radiology Department of the University of Cincinnati College of Medicine under the direction of Benjamin Felson, M.D., professor and head of the department. The course will include lectures, demonstrations, and teaching methods. Further information may be obtained by writing Jerome F. Wiot, M.D., Department of Radiology, Cincinnati General Hospital, Cincinnati 29, Ohio. The course is open to radiologists and radiology residents.

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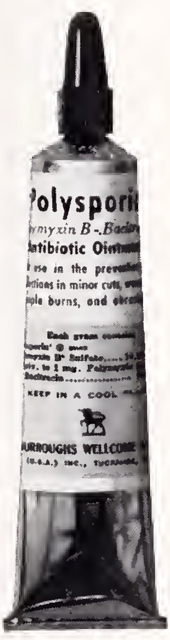

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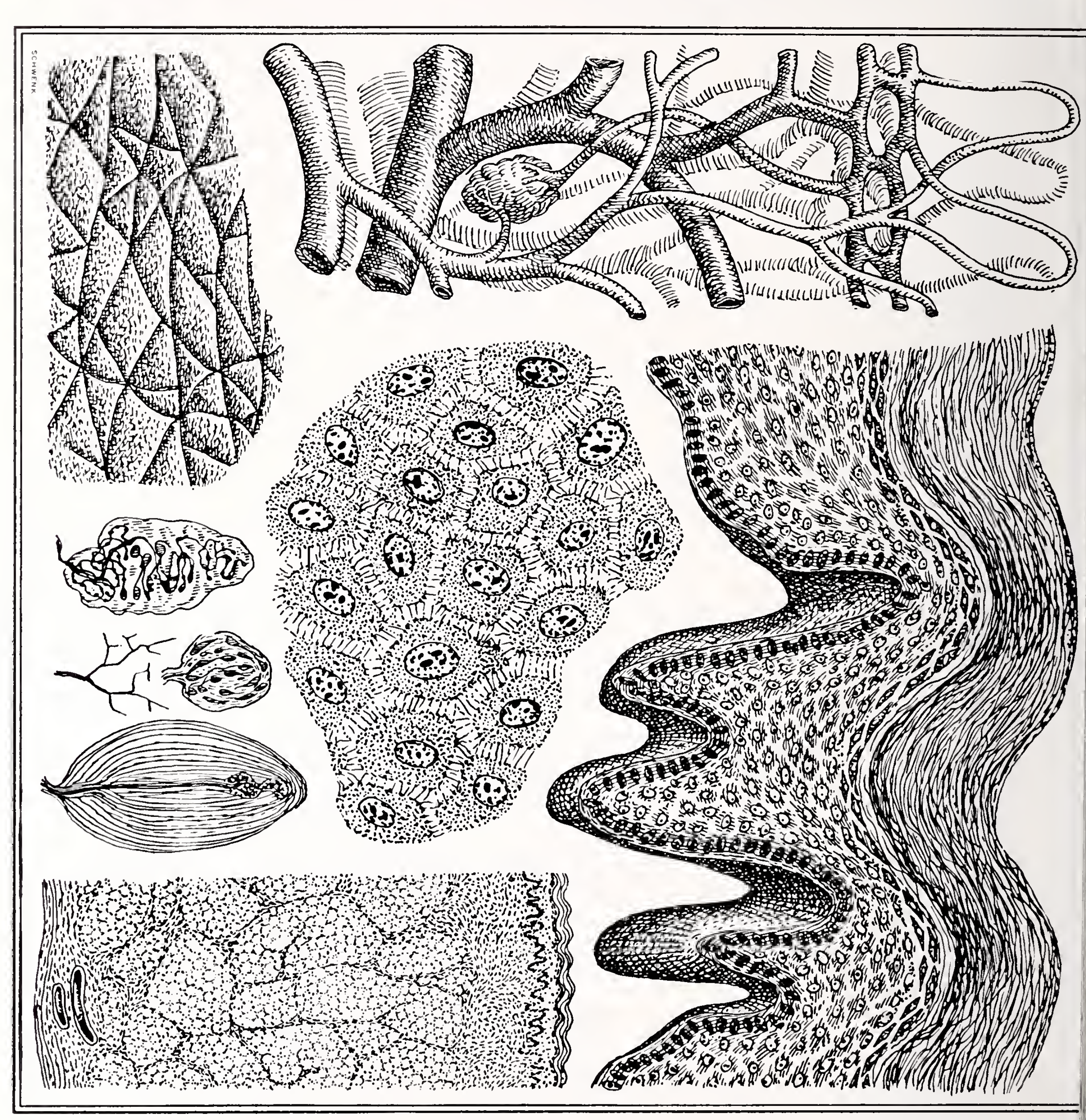
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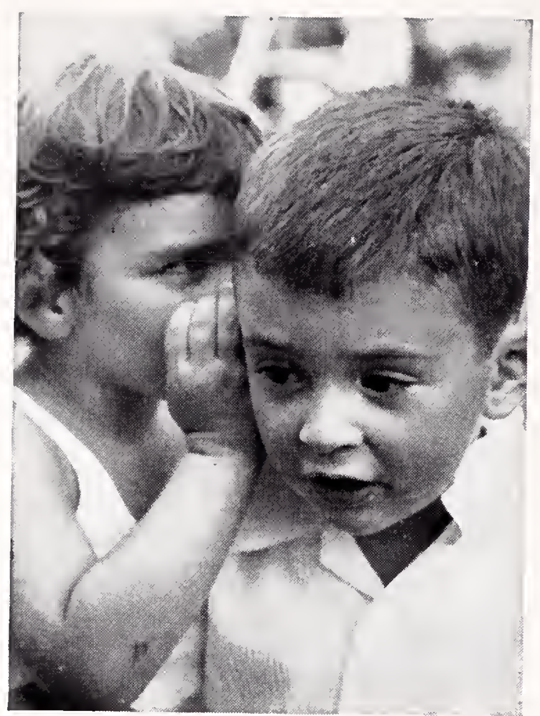

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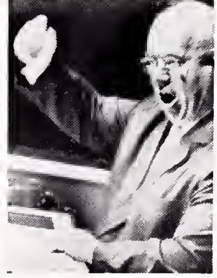

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WASHINGTON NEWS DIGEST

WASHINGTON, D. C.—A presidential advisory commission urged a massive attack by the federal government on illicit traffic in narcotics and dangerous drugs. The commission recommended establishment of a special unit of investigators and lawyers in the Department of Justice to hunt down and prosecute big-time smugglers and sellers.

For the addict, the commission suggests more emphasis on rehabilitation rather than punishment. The commission said penalties in federal narcotics laws are too rigid for some of the lesser offenses and urged that these be relaxed to give courts more discretion in dealing with these offenders.

In an interim report, the commission also touched on the controversial question of whether drugs should be dispensed to addicts in treatment by physicians. It recommended that the American Medical Association and the National Research Council "submit definitive statements as to what constitutes legitimate medical treatment of an addict, both in and out of institutions."

The commission said it intends to make an intensive study of the issue of discipline versus rehabilitation in the treatment of drug abusers. It said it considered a combination of the two approaches best.

Other major recommendations included: Stricter control of the manufacture and use of the so-called "dangerous drugs," such as barbiturates and amphetamines. A comprehensive research program into all phases of drug abuse. Establishment of a joint United States-Mexican commission to control the illicit traffic of narcotics and drugs from Mexico into the United States.

On the same day, the New York Academy of Medicine issued a report sharply attacking what it called the Federal Bureau of Narcotics' "punitive attitude" of treating drug addicts as criminals and attempting to control addiction by imposing stiff legal penalties. The report of the New York physicians charged the Bureau of Narcotics with forcing "unsound" medical treatment of drug addicts, intimidating doctors who attempt to treat addicts and generally holding back "progress in the conquest of addiction."

* * *

The Department of Health, Education and Welfare licensed the manufacture of both a live-virus and a killed-virus measles vaccine. Merck Sharp and Dohme, Philadelphia, was licensed to market a live-virus measles vaccine and Charles Pfizer & Co., New York City, was licensed to market a dead-virus vaccine in what health officials foresaw as the weapons for possible victory in the age-old battle against this persistent and often serious ailment.

Merck Sharp and Dohme made available a limited quantity of the live-virus vaccine throughout the United States within two days of the licensing on March 21.

Surgeon General Luther L. Terry of the Public Health Service urged inoculation of any child under the age of six who had not had measles. Hugh H. Hussey, M.D., director of the American Medical Association's Division of Scientific Activities, said the new vaccines made it possible to launch an all-out attack against one of the most common childhood diseases.

Both HEW Secretary Anthony J. Celebrezze and Doctor Terry were optimistic about the possibility of the vaccines putting the nation on the road toward elimination of the disease.

A Surgeon General's advisory committee on measles control, composed of government and non-government experts, suggested most physicians would want to administer the live vaccine, with an accompanying shot of gamma globulin to reduce reactions. One injection of the live vaccine has conferred complete immunity to more than 95% of those vaccinated and susceptible to measles. But when given alone it produces side reactions, including a rash and a fever of at least 103 degrees, in 30% or more of those vaccinated.

The advisory committee said the killed vaccine, because of its poorer immunizing qualities, should be used only where the live product wasn't suitable. Experts said the live vaccine's protection was as good as that resulting from the natural disease and had been demonstrated to last more than four years.

The estimated number of measles cases in the U. S. was 6,800,000 in 1962 and averages at least 4,000,000 a year annually. In 1961 there were 434 deaths from measles.

Government health officials said they anticipated no federal financing or distribution of the measles vaccine. It was expected the distribution will be through physicians in private practice or through community "well baby" clinics.

* * *

The Food and Drug Administration banned the use of menadione, vitamin K-3, in foods and food supplements. An FDA spokesman said the ban was ordered because the agency decided that the manufacturer had not provided sufficient data under the food additive law to prove compliance with safety requirements. However, the spokesman denied reports that use of menadione posed a serious danger to unborn infants. He said expectant mothers who had taken it in prenatal vitamin capsules should not be alarmed.

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Doctor's Day Observed March 30 in State

Doctor's Day was observed across the state of Kentucky on March 30 by the various county medical society women's auxiliaries, in keeping with a program of the Woman's Auxiliary to the Southern Medical Association.

Members of the medical profession are honored annually throughout the southern states on March 30, the date chosen to commemorate the day in 1842 when a Georgia physician, Crawford Long, M.D., first administered ether in a surgical operation. Doctor Long studied medicine at Transylvania University in Lexington.

Among the groups celebrating Doctor's Day in Kentucky were the Fayette County Medical Society Auxiliary, the Laurel County Medical Society Auxiliary, and the auxiliaries of the Mason County Medical Society and the Pulaski County Medical Society. Also honoring the profession were the wives of Taylor County physicians, and the Daviess County Medical Society Auxiliary.

News Items

John C. Hagan, M.D., has begun general practice at North Middletown, Ky. Doctor Hagan was graduated from the University of Louisville School of Medicine in 1961 and interned at the University of Kentucky Medical Center.

County Society Reports

Graves

R. L. Colley, M.D., was elected president of the Graves County Medical Society, succeeding Jacob Mayer, M.D. Other officers elected at the March meeting were Don Haugh, M.D., vice president; J. R. Van Arsdall, M.D., secretary; Harry Roach, M.D., and Jacob Mayer, M.D., directors. John Reed, M.D., was named official delegate to the Kentucky State Medical Association, and Robert Orr, M.D., alternate delegate. All are from Mayfield.

McCracken

Robert Rickie, M.D., and James O'Neill, M.D., both of the Department of Surgery, Vanderbilt University Hospital, presented the Scientific Program at the regular meeting of the McCracken County Medical Society. Doctors Rickie and O'Neill gave a resume of "Recent Developments in Gastric Freezing as a Treatment for Duodenal Ulcer."

At the same meeting William W. Myre, M.D., Paducah, Chairman of the Public Relations and Legislative Committee, was appointed Key Man.

The testing of drugs for human use will always be a bit like a proposed swim in an inviting pool: one can never experience fully the feel of the water until one's own hesitating foot has been resolutely, unwaveringly, and irrevocably dipped beneath the surface.

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References: 1. A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963. 2. Gruenberg, F.: Curr. Ther. Res. 2:1 (Jan.) 1960.

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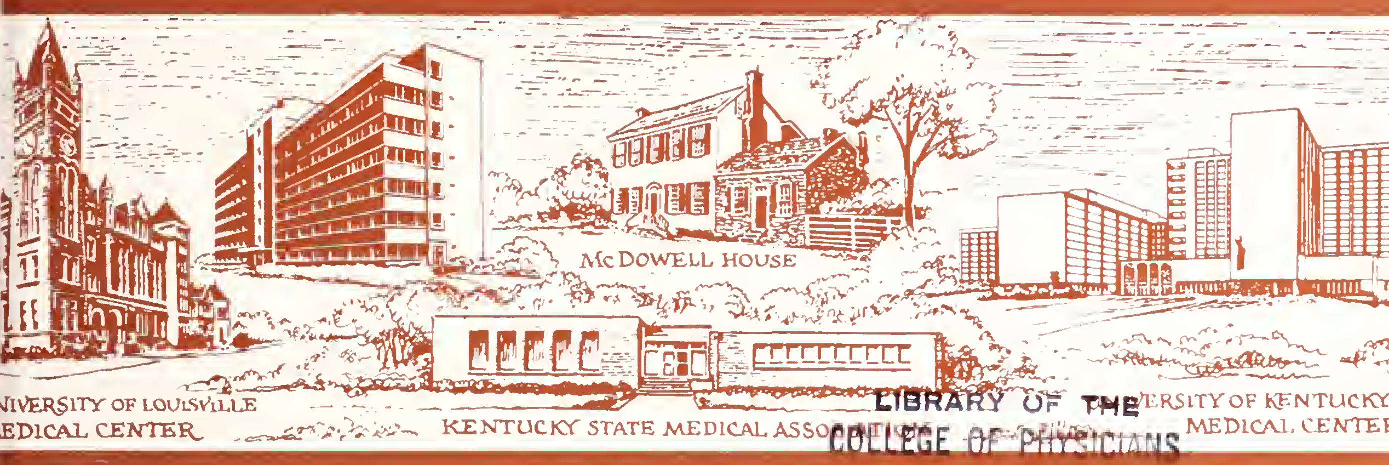

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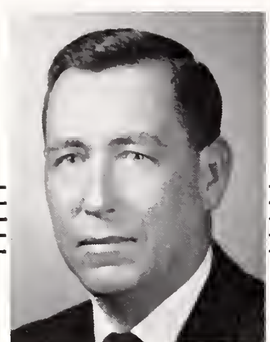

That There Be No Divisions Among You† *

THE above advice given by the Apostle Paul to the early church at Corinth should serve as an example in the solution of many problems in our profession.

First of all, let all of us remember that we are physicians dedicated to the care of our patients in the best possible way. At all times may our care and interest in the patient be such that it will reflect the glory of the profession rather than of any institution with which we may be associated.

It seems to me that the profession as a whole should restudy its position in reference to the great shift to specialization in the past ten years. Is the G.P. obsolete? Have we been oversold with the idea that medicine is growing so fast that the general practitioner is unable to "keep up"? Only two basic eras have passed: the antibiotic-chemotherapeutic, and the concept that the body can tolerate much more surgery and recover.

I am sure that the G.P. will not be able to keep up with the progress if he is denied the use of the tools of his profession and prevented from performing procedures he is capable of doing and for which he is trained. The public status of the G.P. still exists, and only within his profession has his position deteriorated in the past few years.

Until concepts change in teaching, conflicts of interest no longer exist between various groups, and the realization comes that most people still get sick and die with the common, ordinary garden variety of diseases, the G.P. will continue to be overworked, and inroads by "Cults" will have the greatest chance to make progress.

Joseph R. Miller, M.D.
KSMA Vice President (Western)

† *Corinthians I, Ch. I.*

* *This is the third in a series of guest articles written at the request of the president of the Kentucky State Medical Association, by the vice presidents of KSMA and the president of the KSMA Women's Auxiliary.*

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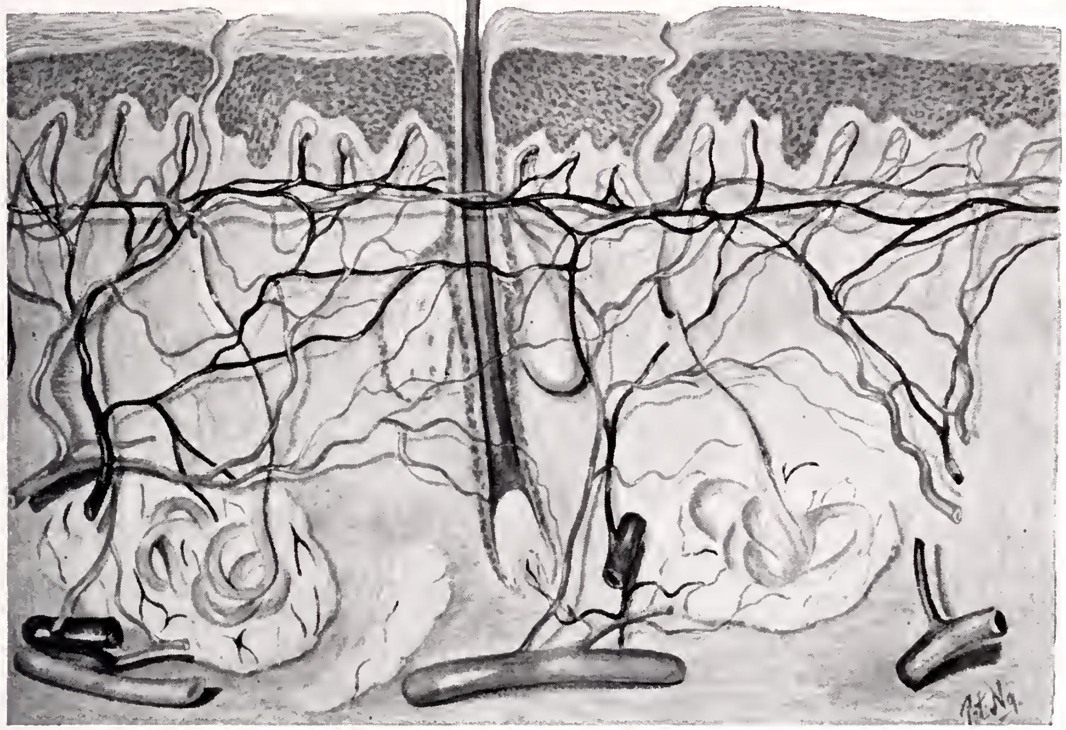

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THE INSURANCE PAGE

The Professional Services Index*

AS a result of a need of the people, the Kentucky Blue Shield Plan was established in 1949 by the Kentucky State Medical Association.

A schedule of allowances for covered professional services had to be formed without the benefit of previous experience or the mechanisms of today which greatly assist in equitably establishing allowances with the proper relationship of one procedure to the other.

The result was a contract that served a real purpose in helping fulfill the need for a prepayment plan but, subsequently, experience with professional services and fees over the years helped show some of the inequities that existed in the schedules. This same problem was found in most Blue Shield Plans across the country when they began negotiating national accounts.

The National Association of Blue Shield Plans, recognizing the need for a base upon which schedules could be prepared in order to effectively serve the public and to be in keeping with medicine's view on schedules, decided to develop an index that could be used and would reflect the realtionship between different professional services. They were assisted by specialty group committees of the American Medical Association.

The result of the work of the Committee on Professional Services was the Professional Services Index.

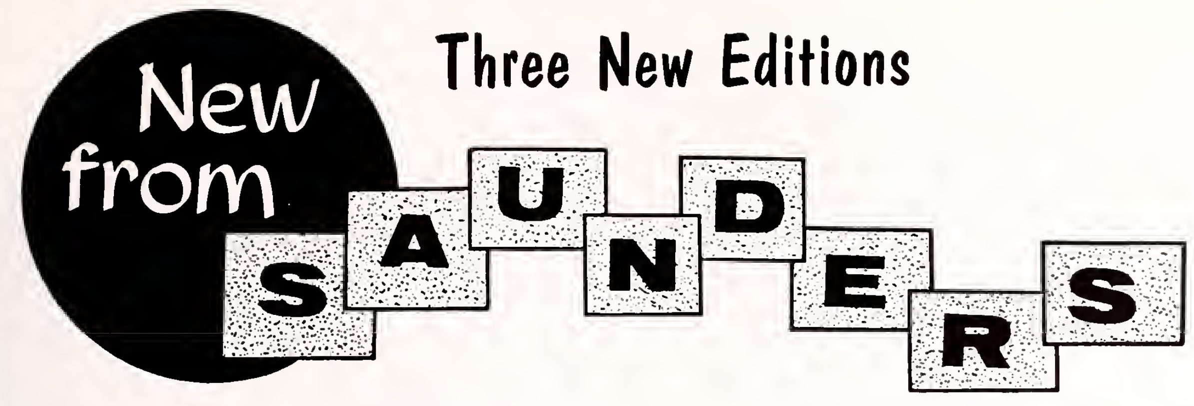
Upon close study by our Blue Shield Board of Directors and staff, a decision was made to use the Professional Services Index for National Account Schedules and further to develop new schedules so as to conform to the Professional Services Index. This action will give Kentucky subscribers better schedules at a slightly higher cost and the allowances will be more in line with the system of establishing charges by Kentucky physicians.

The new Schedules C and D are now being offered to all Blue Shield subscribers and to new applicants on a voluntary basis. This represents another progressive step by medicine to allow people to help themselves voluntarily.

W. VINSON PIERCE, M.D.

**This is the first of a series of two articles on this important subject. The second article will appear in the July issue.*

Three New Editions



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By Ernest Aegerter, M.D., Professor of Pathology and Director of the Department of Pathology, Temple University Medical Center and School of Medicine; Professor of Orthopedic Pathology, University of Pennsylvania Graduate School of Medicine; Chief in Pathology, Philadelphia General Hospital; and John A. Kirkpatrick, Jr., M.D., Radiologist, St. Christopher's Hospital for Children; Associate Professor of Radiology (Pediatrics), Temple University School of Medicine; Radiologist, Children's Heart Hospital. About 800 pages, 6½" x 9¾", with about 541 illustrations. About $16.00.

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By George C. Andrews, M.D., Clinical Professor of Dermatology (Ret.) and Anthony Domonkos, M.S., Assistant Clinical Professor of Dermatology, College of Physicians and Surgeons, Columbia University. About 752 pages, 7" x 10", with about 596 illustrations. About $18.00.

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Answers To Questions About Your

BLUE SHIELD

Q. How many 65 and over Kentuckians were enrolled in Blue Shield in the October, 1962, "Senior Citizens" Program?

A. Eighteen hundred and thirty.

Q. What did Participating Physicians in the Senior Citizens Program agree to?

A. They agreed to make no charge to the patient above the Blue Shield allowance if income of the people 65 or over does not exceed the amounts shown below. These are:

All individuals accepted by Kentucky Physicians Mutual, Inc., who are 65 years of age or over, are residents of Kentucky at the time of application and whose "gross annual income from all sources" is $2500 or less for a single person and less than $4000 in combined income for husband and wife, and who are not eligible to receive additional benefits from any insurance policy or action at law.

Q. How many physicians are participating in the Senior Citizens Program?

A. 979 Kentucky physicians have signed agreements as of April 10, 1963. Additional agreements are received and processed each week.

Q. How do I become a participating physician in the Senior Citizens Program?

A. All Doctors of Medicine licensed under Kentucky's Statute 311 are eligible. Upon request to the Kentucky State Medical Association, agreements will be sent you to be signed in duplicate. When returned, these agreements will be countersigned by the President of Kentucky Physicians Mutual, Inc., and one copy will be returned to the physician for file.

Q. What percent of Kentucky physicians who treat older people are participating in the Senior Citizens Program?

A. More than fifty percent of those doctors who normally render services to people over age 65 are now participating.

Q. Since January 1, 1963, how many Senior Citizen members have had claims paid?

A. Eighty.

Q. Are there other age 65 or over persons in Kentucky who are Blue Shield members?

A. Yes. In all, there are over 80,000 in Kentucky. Blue Shield permits continuation of protection regardless of age, state of health, or retirement.

Q. Are there waiting periods under the Senior Citizens Plan?

A. Yes. There is a six-month waiting period from the effective date (January 1, 1963) for any pre-existing condition, known or unknown. This restriction ceases to exist on July 1, 1963.

Q. What in-hospital medical service is provided for in the Senior Citizen Certificate?

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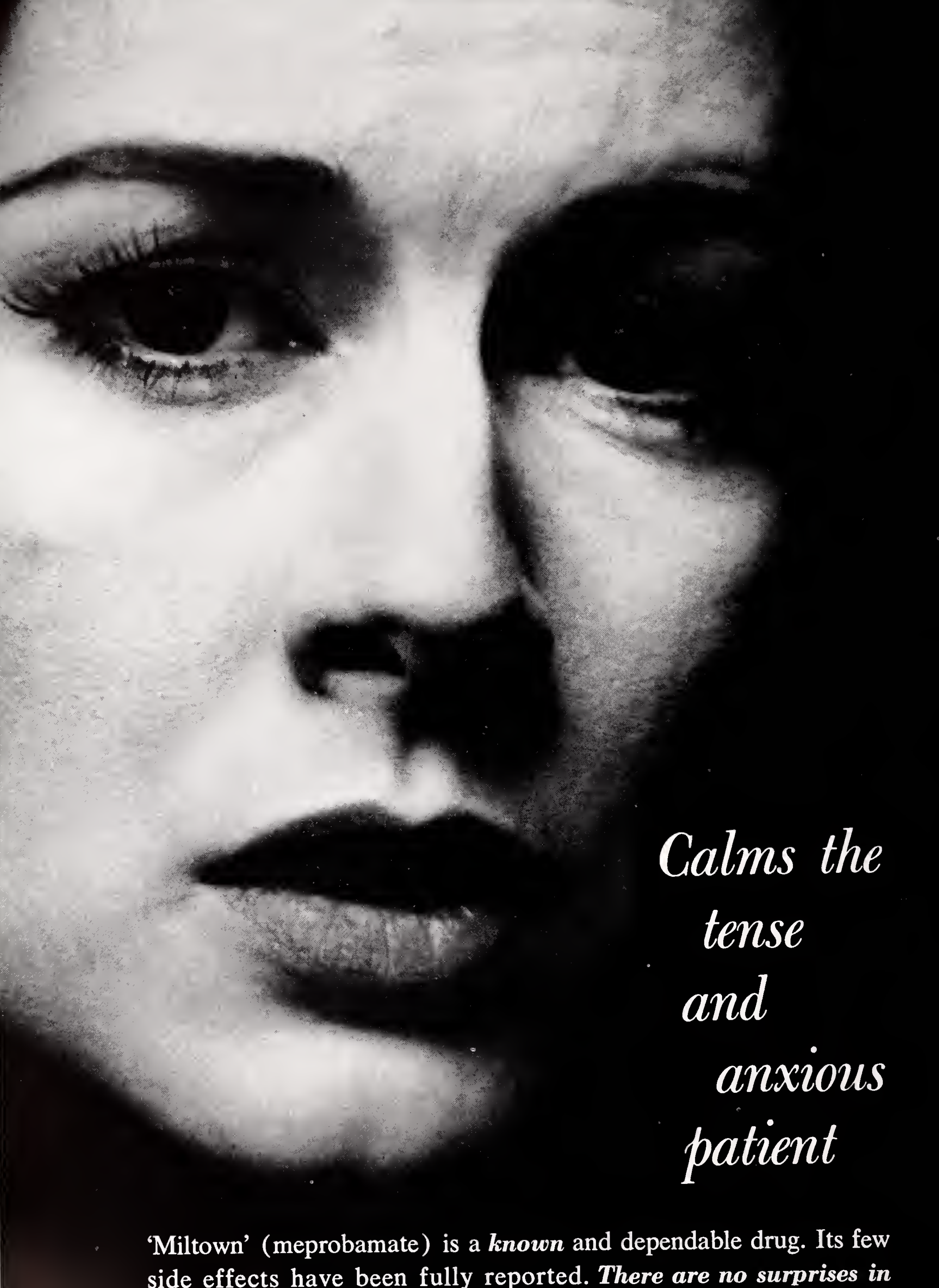

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Poythress, White Section, Page 808 (1963 edition)
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WASHINGTON NEWS DIGEST

WASHINGTON, D.C.—Congressional passage of the Administration's medical education bill appeared assured following a 288-122 vote of approval in the House. Backers of the bill predicted the Senate would pass it overwhelmingly.

The key vote in the House came on the disputed provision for a federally-administered loan program for medical and other students. This was upheld by a 188 to 150 tally, paving the way for final House approval.

Although the Administration had sought a ten-year, $755 million program of grants for the construction of medical schools and for loans, the House Commerce Committee reduced the program to three years and $236 million in order to give Congress power to review progress periodically.

As approved by the House, the bill calls for a $175 million program of matching grants for the construction, replacement and rehabilitation of schools for physicians, pharmacists, dentists, optometrists, nurses, and professional public health personnel. Also in the bill is a $61 million loan program for medical, dental, and osteopathic students.

Student nurses also might be eligible under a provision giving the HEW Secretary authority to extend the loans to other health professions if there is a shortage in a particular category.

The American Medical Association endorsed the construction feature of the bill and opposed the loan plan on grounds it "is not necessary since most of the demands are clearly being met by privately sponsored programs," including the AMA's own plan.

Under the construction part of the bill, medical and allied schools would get $105 million in matching grants, dental schools would get $35 million, and $35 million would be for renovation of existing facilities in medical and allied schools.

The loan program provides individual loans not exceeding $2,000 a year. Interest would be a minimum of three per cent or the going federal interest rate, whichever is higher. A "forgiveness" feature for part of the loan for duty in physician shortage areas or in the armed services was stricken from the bill on the House floor.

* * *

The government's major medical research branch, the National Institutes of Health, had its budget trimmed slightly by the House, the first time in recent years NIH hasn't received a hefty boost over the Administration's request.

The House voted $962.4 million for NIH, $18 million less than called for in the budget, but still a record total and $31 million above this fiscal year's sum.

The HEW Department as a whole received $5,021,759,000 from the House, $263 million under the budget proposal and $150 million less than appropriated last year. Much of this reduction, however, involved public assistance funds which would have to be restored if the money is needed.

The Public Health Service had its budget slashed $51.8 million, receiving a total of $1.5 billion.

Food and Drug Administration appropriations of $40 million were $9 million less than requested but $11 million more than last year.

The Hill-Burton program of hospital construction aid received $177.9 million, almost as much as the request, but $48 million less than last year.

The House Appropriations Committee warned NIH in its report to "exercise a high degree of vigilance "that its actions tightening supervision of research grants" not diminish the basic independence and integrity of our institutions of higher learning and the essential conditions of scientific freedom."

The committee said it has been concerned with reports that steps taken by NIH "seriously threaten the freedom of scientists and that they constitute evidence of federal control over science."

Meantime, a House Commerce subcommittee headed by Rep. Kenneth Roberts (D., Ala.) started hearings on charges NIH has been lax in management of research grants and funds. Another purpose of the hearing was to determine whether Congress should keep a closer check on NIH expenditures. U. S. Surgeon General Luther L. Terry told the subcommittee that most of the criticism of the government's medical research activities was unjustified. Dr. James Shannon, head of NIH, said 50 administrative steps have been taken in the past year to make sure NIH money is properly spent.

* * *

Sen. George Smathers (D., Fla.) and Rep. Wilbur Mills (D., Ark.) introduced similar bills requiring states to provide medical care for the indigent equal to the protection given the elderly under the Kerr-Mills Act provision for the medically indigent.

"It seems poor policy to us to provide less in the way of medical care to persons on old-age assistance, who require help with their day-to-day living expenses," Smathers said, "than we provide to the recipients of medical assistance for the aged who have enough resources to meet their regular expenses other than medical bills."

Rep. Mills is chairman of the House Ways and Means Committee. Sen. Smathers is a high-ranking member of the Senate Finance Committee and chairman of the Special Senate Committee on Aging. Their proposal was part of two programs carrying out President Kennedy's recommendations designed to help the elderly.

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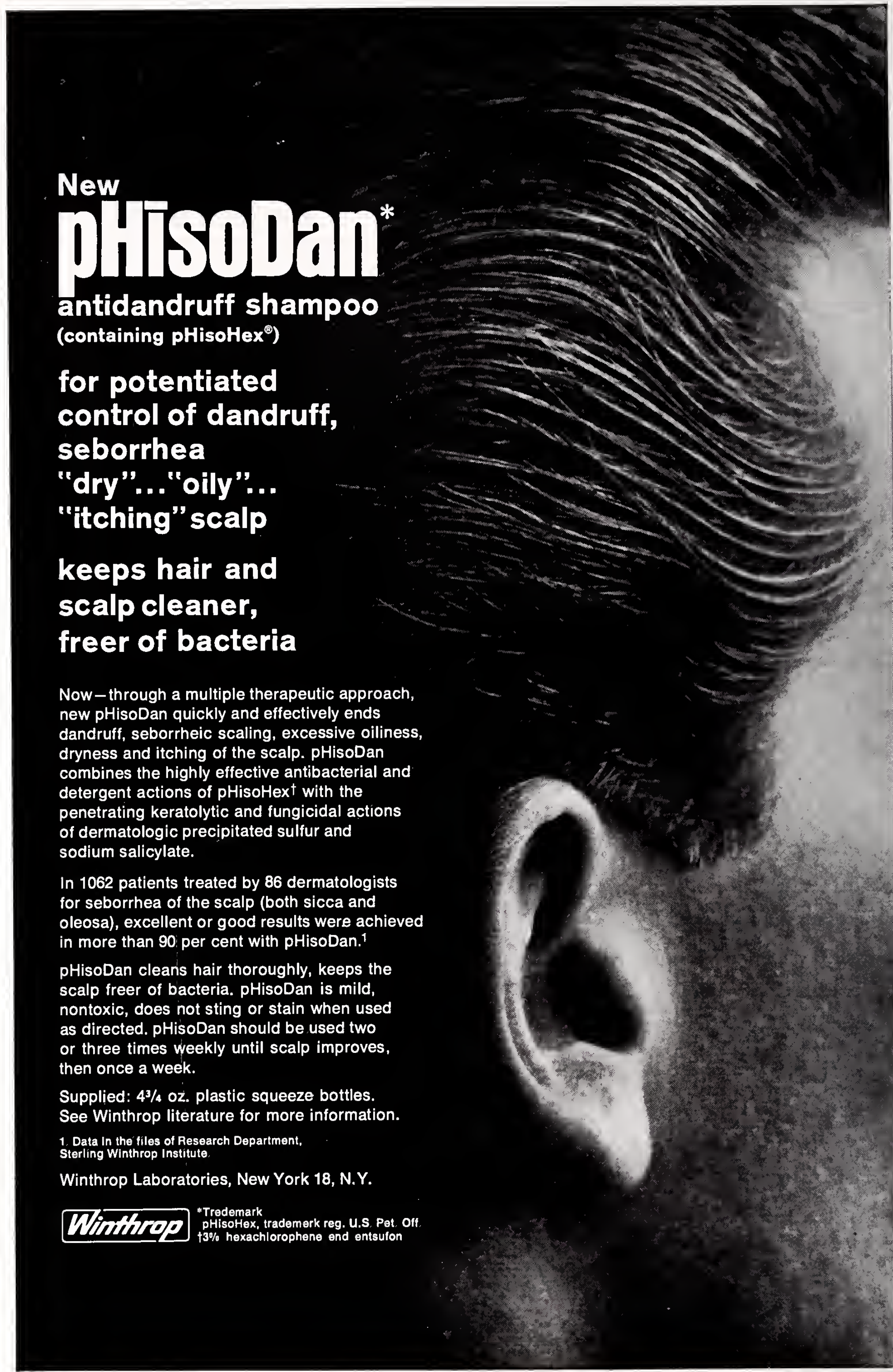
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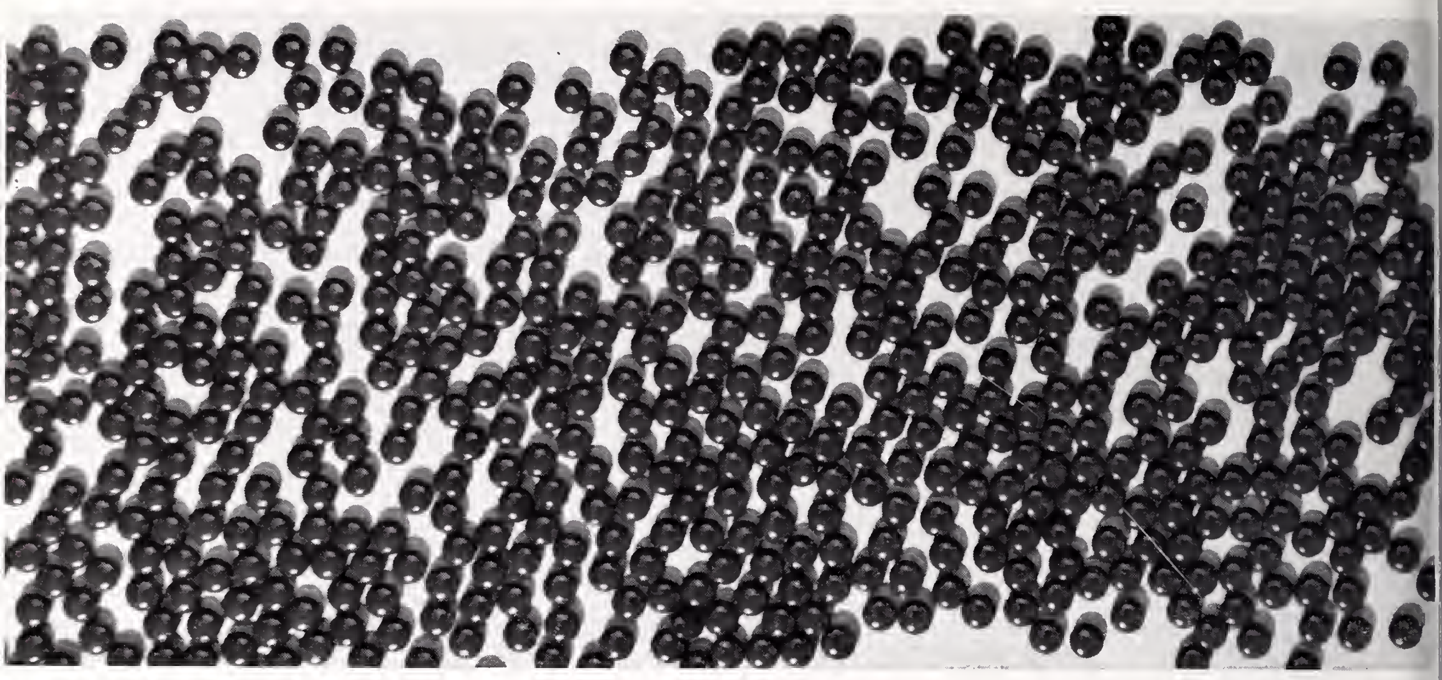

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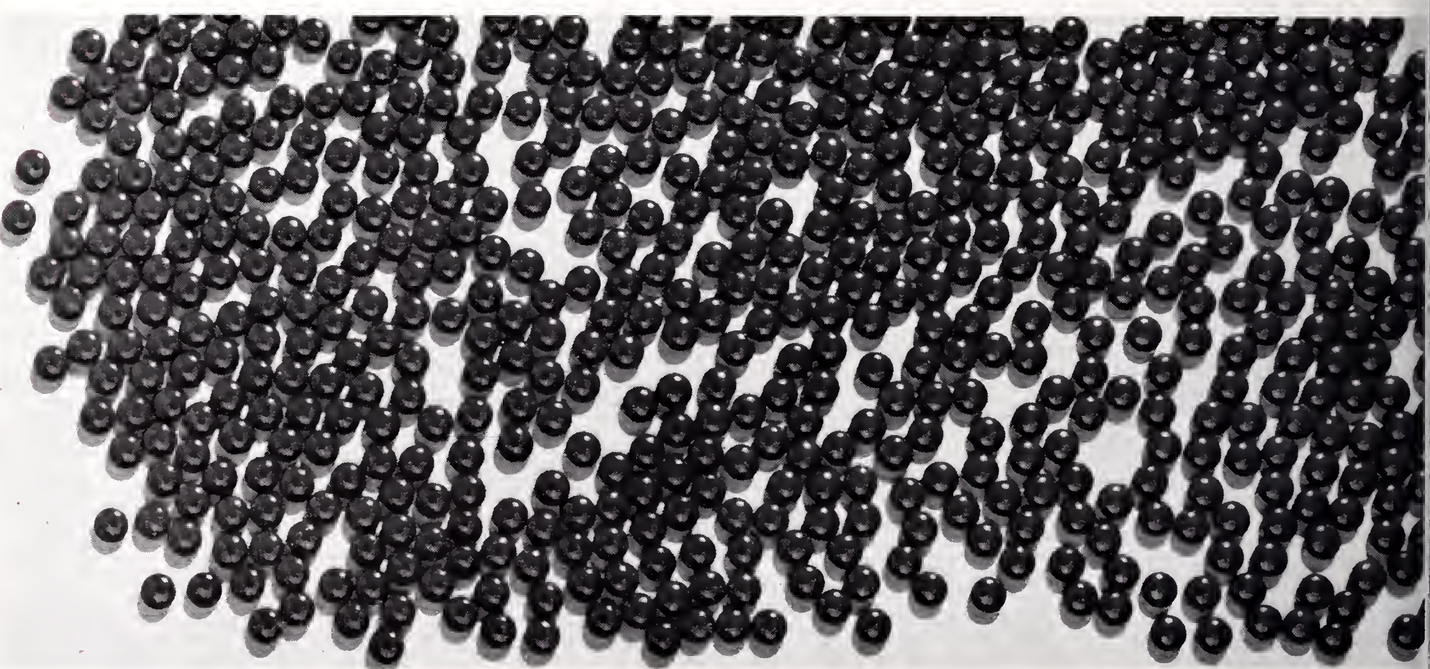

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Medical Care, Cardiovascular Surgery and Obstetric Management in the Pregnant Cardiac Patient*

CURTIS L. MENDELSON, M.D., F.A.C.S., F.I.C.S.
Abaco, Bahamas

Supportive care, cardiovascular surgery and therapeutic abortion are employed in the management of heart disease complicating pregnancy. Each plays a definite role and none is a panacea.

PREGNANCY imposes a significant and predictable circulatory burden from increases in oxygen consumption, cardiac output and blood volume. This burden starts in the first trimester, increases progressively throughout the second trimester, and decreases toward term. Transient rises occur during labor and immediately following delivery, but not to the high antepartum levels. A return to the normal nonpregnant level occurs by the second postpartum week.

The normal pregnant woman exhibits physiologic deviations that can be misinterpreted to indicate organic heart disease. These include changes in cardiac contour and electrocardiographic pattern, systolic murmurs, accentuated and split heart sounds, dyspnea, edema, capillary pulsation, transient basilar rales and increased venous pressure in the lower extremities.

Two to four per cent of all pregnancies are complicated by organic heart disease. Over 90% of cases are of rheumatic origin, and mitral stenosis is the sole or significant lesion in the majority of instances.

Heart Failure

Heart failure is a major cause of maternal mortality. The onset of severe decompensation and the time of death are related most often to the hemodynamic burden of pregnancy rather than to the natural course of underlying heart disease.

Ordinarily, heart failure during pregnancy is left-sided, and the greatest number of deaths is caused by fulminating pulmonary edema. In respect to this problem, the New York Heart Association's functional classification provides the most important guide to prognosis.

Maternal deaths may result from other cardiovascular complications such as vascular accident, bacterial endocarditis and postpartum venoarterial shunt with vascular collapse. The incidence of these complications bears no relation to functional classification.

There is no evidence that childbearing causes permanent deterioration of the cardiac status, or that it shortens life expectancy, provided the patient survives each pregnancy.

Experience has demonstrated that cardiovascular surgery prior to and during pregnancy may render childbearing safe in patients in

*Presented at the First Scientific Session, Kentucky State Medical Association Annual Meeting, September 18, 1962, at Louisville, Ky.

whom the risks of severe heart failure or other complications may have been prohibitively high. Urgent life-saving operations can be performed during pregnancy without increased surgical risk to the mother, and without jeopardizing the baby. In fact, statistics indicate that operation prior to or during pregnancy decreases maternal and fetal mortalities.

Except in certain cases of kyphoscoliosis, coarctation of the aorta, aneurysm and previous subarachnoid hemorrhage, heart disease is not an acceptable indication for hysterectomy, hysterotomy, induction of labor or Cesarean section. However, postmortem Cesarean section should always be performed if the mother dies undelivered and the baby is viable.

The majority of cardiac patients tolerate spontaneous term labor, which is more efficient and less burdensome upon the heart than induced premature labor. The total cardiac burden of labor and vaginal delivery does not equal that of the late second and early third trimesters.

During labor, the pulse rate gives warning of impending heart failure sufficiently in advance to permit prophylactic measures to be instituted.

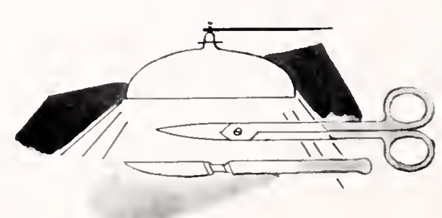
Therapy

Demerol® with or without scopolamine is used as premedication for cardiac patients in labor, unless the delivery is premature, in which event atropine alone may be used. The preferred anesthetic technique and agent involve induction with nitrous oxide or cyclopropane, followed by administration of ether with oxygen in high concentration. Postdelivery rebreathing of 100% oxygen and administration of antibiotics minimize the incidence of pulmonary complications. Regional anesthetics have disadvantages that outweigh their advantages; when inhalation agents are contraindicated, local infiltration or field block is recommended. The use of Pentothal® sodium is not advised.

After delivery, ergotrate and Pituitrin® are avoided. Pitocin® or Syntocinon® (which is free of pressor substance) is used instead. Intravenous fluids are avoided. The use of broad-spectrum antibiotics, initiated during labor, is continued during the puerperium when it is necessary to avoid infection (as in rheumatic and in congenital heart disease where the danger of bacterial endocarditis exists). Certain cardiac patients are discouraged from nursing.

Sterilization is not recommended for patients with severe heart failure during pregnancy. Cardiovascular surgery has decreased the indications for sterilization, and sterilization is no longer an acceptable corollary to interruption of pregnancy. Information concerning contraception should be given to patients for whom additional pregnancies are contraindicated. Medical supervision of cardiac patients should be arranged before they are discharged from the hospital.

Generally, maternal cardiac disease does not by itself affect the incidence of spontaneous abortion or of premature labor, the duration of labor or the blood loss at delivery. Fetal morbidity and fetal mortality result mainly from obstetric intervention, antepartum death of the mother, and other underlying medical or obstetric complications.



Changing Concepts in Thyroid Disease*

Walter I. Hume, Jr., M.D.**, and Ralph M. Scott, M.D.***

Louisville, Ky.

The function of the thyroid is reviewed, as are the diseases which affect it. Therapy available is outlined, and note is made of the marked changes in treatment in the last two decades.

THE ADVENT of the atomic age has wrought more changes in the testing and treatment of throid desease than in perhaps any other segment of medical practice. We propose here to review briefly the impact of these changes on our knowledge of the function of the thyroid gland, its disease processes, and our available modes of therapy.

Physiology

What is the normal function of the thyroid?

A brief review of what the thyroid gland does may be of interest, and the following discussion is based on a fine recent review by Hamolsky and Freedberg.[1] Thyroid function can be divided into a number of steps (see Figure 1): Step 1 is the uptake of the iodine. Step 2 is its involvement in the thyroid gland in a thyroid hormone (basically thyroxin, contained in the thyro-globulin, which is in turn contained in the intrafollicular colloid material). From here as a third step the hormone is liberated into the blood stream, and it is liberated primarily in the form of thyroxine—tri-iodothyronine and other compounds amount to 10% or less of the thyroid hormonal activity.

It is then (step 4) combined with protein in the circulating blood stream, and this protein, it is now thought, is primarily one of the inter-alpha globulins (some researchers have thought it may be one of the prealbumin factors). Step 5 is the entry of the hormone into the cells, and no one really knows how it gets into the cells or at what particular portion of the cellular metabolism it exerts its effect.

The sixth step is the utilization of the hormone by the cells, for its metabolic and calorigenic effect. Then we have a couple of other steps: (7) A hormone from the anterior pituitary (TSH) also works to stimulate the thyroid hormone and this in turn is also affected (8) by the central nervous system from the hypothalamus.

In another step (9) we find that when the level of circulating hormone in the blood stream is high, there is a feed-back mechanism which decreases the amount of thyroid stimulating hormone produced. (An interesting point is that it was found not too long ago that TSH is not elevated in thyrotoxicosis, and this therefore infers that TSH may contain multiple fractions, one fraction producing exophthalmos and the other thyrotoxicosis; there is some research evidence to indicate that there may actually be two or more such hormones.) Then in the tenth step, the hormone is excreted by the kidney.

This gives some idea of the normal pattern of function of the thyroid gland and its hormones.

Pathophysiology

What can go wrong with the thyroid?

A. What can go wrong functionally?

We can have either an increase or a decrease in normal function, and these changes of course are known as hyper- and hypothyroidism. There are some tests which are well known, and some which are fairly new, which will help us diagnose these changes in function.

(1) Among the standard tests is the BMR

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* *Presented at the Surgical Staff Conference at Louisville General Hospital, March 26, 1962.*

** *Assistant Professor of Surgery, University of Louisville Medical School.*

*** *Director of Radiotherapy, Louisville General Hospital, and Associate Professor of Radiology, University of Louisville Medical School.*

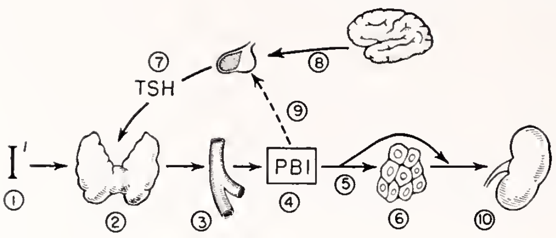

Figure 1.

(which basically tests step 6 in Fig. 1); it is certainly still a reasonable screening examination. It is, of course, valuable when low, not necessarily so valuable when elevated.

(2) Determination of the serum protein bound iodine measures step 4 in the metabolism of the iodine and it depends on the previous and the subsequent steps 3 and 5, the liberation of the hormones into the blood stream and its pick-up by the cells. The protein-bound iodine test is well known; it can be elevated in a number of conditions besides hyperthyroidism (pregnancy, hepatitis, exogenous iodine administration, etc.) and it can be depressed in a number of conditions besides hypothyroidism (nephrosis, some cases treated with cortisone, or with tri-iodothyronine).

(3) A third major diagnostic study is determination of radioactive iodine uptake; it measures, in Fig. 1, steps 1, 2, 3, 7 and 10.

There are some newer tests that aren't necessarily used in every case: The thyroid plasma iodide clearance test measures how fast the plasma clears itself of radioactive iodine; the conversion ratio is another test which measures how rapidly the radioactive iodine is converted in the plasma from the circulating injected radioactive iodine into protein bound radioactive iodine. Then there is the red cell uptake of I_{131} in vitro; this is an interesting test, recently prepared, whereby the red cells, outside the human body, are subjected to metabolic studies of uptake of I_{131}. This is not universally available but has the obvious advantage that radioactive substances are not injected into the patient at any stage.

Other tests: Thyroid suppression test—a radioactive iodine uptake test is done, exogenous thyroid is given for a couple of weeks, and then another radioactive iodine uptake is done. The idea here is that the euthyroid individual is suppressed in the subsequent follow-up iodine uptake whereas the hyperthyroid individual is not comparably suppressed. This offers a means of differentiation between the euthyroid and the hyperthyroid individual. The TSH test is essentially the same: Radioactive iodine uptake is done, then thyroid stimulating hormone is given for a couple of weeks and then radioactive iodine uptake is again done—this differentiates pituitary myxedema from primary myxedema.

Among other tests using radioisotopes there is the use of I_{131} in vivo for localization of functioning thyroid tumor. Functioning metastatic carcinoma can be identified with radioactive isotopes, and nodules can be diagnosed as being "hot" or "cold"; it is of interest that the "hot" nodules are rarely carcinoma. These are some of the tests that can be used to tell us whether we are dealing with a functionally normal, over-stimulated or under-stimulated thyroid gland. The three standard tests are the BMR, PBI and RAI uptake tests, the others are of interest in special instances.

B. What can go wrong anatomically with the thyroid?

The gland can increase in size. The enlargement may be diffuse or nodular. The symptoms are usually dysphagia or dyspnea; the cosmetic deformity associated with a very large gland may occasionally warrant surgical relief in the absence of such symptoms.

C. What can go wrong immunologically?

This is a field that has been increasingly investigated in the last few years. It has been proved that in Hashimoto's struma there are circulating anti-thyroid antibodies, and it may well be that in other cases of thyroiditis the concept of auto-immunization may play a major part. Thyroiditis as an entity rarely requires surgical relief.

D. What can go wrong histologically?

Carcinomatous transformation; essentially a loss of self control in reproduction. From 10% to 20% of single nodules of the thyroid are found to contain carcinoma[2]; histologic examination is the only reasonable diagnostic test.

Treatment

What can we do about thyroid abnormalities?

This discussion will follow the general outline of abnormalities listed above.

A. Thyrotoxicosis.

The three major approaches are surgery,

anti-thyroid drugs, and radioactive iodine. Of the three, anti-thyroid drugs have been used mainly in recent years as precursors to surgery; occasionally patients are able to stay on prolonged courses of anti-thyroid drugs, then omit the drugs and remain well. The choice of therapy, however, basically falls between radioactive iodine and surgery.

(1) Radioactive iodine.

Radioactive iodine was first used in the treatment of hyperthyroidism about 1942. At this time, all radioactive iodine was produced in cyclotrons. Its production was difficult, costly, and the supply was low. With the development of nuclear reactors during World War II, an easy way to prepare the substance was made available and a new era was opened in the treatment of hyperthyroidism.

There is still disagreement over the indications for the use of radioactive iodine in thyrotoxicosis, centering around the question of whether or not it may be a carcinogen. Nearly all cases of hyperthyroidism can be controlled with radioactive iodine, but this does not necessarily mean that all of them should be so treated.

The age of the patient is among the criteria used for selection in these cases; originally the age of 40 to 45 was set by most physicians as the dividing line. It was felt that it would take at least ten to thirty years to produce carcinoma, and if radioactive iodine proved to be carcinogenic, a patient treated at age 40 or over would be getting along in years before he developed his malignancy.

Approximately 100,000 people have been treated with I_{131} now, and the incidence of carcinoma in this group has been no higher than in the general population. Accordingly, the age limit is tending to come down. Certainly young persons who have contraindications to surgery are being accepted for treatment, but the age of 40 is still often quoted as a lower age limit.

The sex of the patient is another consideration. The dose to the ovaries in females treated for hyperthyroidism is quite low, being approximately what they would get from one or two GI examinations, so there is little worry about this aspect. So far there have been no undesirable effects reported in the offspring of patients who have been treated with radioactive iodine.

Pregnancy, however, is one of the absolute contraindications to the use of this substance. During the first trimester very small doses of radiation can be harmful to the fetus, particularly during the period of organogenesis. During the second and third trimesters the fetal thyroid can assimilate radioactive iodine through the placenta so we avoid the use of radioactive iodine in these patients. Lactation is another contraindication because the material is secreted in the mother's milk.

Another consideration is the size and type of the gland. The ones best suited for radioactive iodine treatment are the small diffuse goiters. The large diffuse goiters will generally respond well, however, and most of them will get small enough so that they won't present any cosmetic or functional problem.

The real problem is the nodular toxic goiter. Here there is the risk of overlooking a malignancy if the nodule is not resected, and in addition, nodular goiters are very difficult to control with radioactive iodine. The dose required is large, and the distribution within the gland is irregular. If there is a contraindication to surgery such patients can, however, usually be controlled with radioactive iodine.

Radioactive iodine treatment is strongly indicated in a case of hyperthyroidism recurrent after surgery. The isotope emits two types of radiation, beta and gamma, and the beta radiation causes about 90% of the radioactivity. The beta rays from radioactive iodine have a maximum range of about 2mm. and an average range of about ½ mm., so practically no radiation gets outside the thyroid. Consequently there is no danger of parathyroid or recurrent laryngeal nerve damage, and since surgery is much more difficult with these patients the second time, patients with recurrence after previous surgery constitute ideal candidates for control with radioactive iodine. It takes only small doses to bring them under control, however. The danger of hypothyroidism with these is greater perhaps than with any other group that we treat.

Patients with cardiac disease secondary to hyperthyroidism are also probably best treated with radioactive iodine. Although there is some danger of aggravating the heart disease when the thyroid gland pours hormone into the circulation secondary to radiation damage to the follicles, this situation can be avoided by careful management, proper dosage and sometimes

by preliminary treatment with propylthiouracil to deplete the gland of stored hormone.

Patients treated with radioactive iodine usually have very few undesirable side effects. About the end of the first week a few will have some tenderness over the gland. This subsides fairly rapidly. There is little effect from the drug until about the third or fourth week, then most patients will start improving. They will start gaining weight, the goiter will begin to decrease in size, their nervousness will begin to decrease, they will begin to perspire less, they will begin to get stronger, and from about the third or fourth week on they will continue to improve.

The maximum improvement is usually achieved around the tenth to twelfth week. It is difficult to evaluate the result of your treatment before this time. Those patients not measurably better at the end of eight weeks will probably need retreatment.

The incidence of myxedema in the treatment with radioactive iodine is difficult to determine; reports vary from 3% up to 30%. It seems, in most reports, to produce myxedema just about as often as does surgery. There have been some reports recently to the effect that even late after these people are treated, and by late we mean five, or six or seven years after they are treated, there are still a significant number becoming myxedematous; this is something that is just beginning to be realized, and warrants careful future observation. The approach to treatment is changing a bit because of this; instead of giving one dose and trying to control the disease with this, many therapists now give small doses repeatedly to try to get away from the problem of myxedema.

As far as the recurrence rate is concerned, a diffuse toxic goiter controlled for about six months with radioactive iodine, rarely recurs. With a nodular toxic goiter, however, a recurrence can be expected almost any time.

A carcinogenic effect of radioactive iodine has not been established; there are no cases of carcinoma directly attributed to radioactive iodine. There have been two or three cases of leukemia reported in people who have received radioactive iodine, this being no more than would be expected coincidentally.

In summary, radioactive iodine is best used with (1) the small diffuse toxic goiters in the patients past 40, (2) the recurrence postoperatively, and (3) the thyro-cardiacs. In special cases almost anyone can be treated for hyperthyroidism with this agent, but the categories listed above are those in which it is most commonly indicated.

(2) Surgery.

We have mentioned above some of the complications in the treatment of thyrotoxicosis with radioactive iodine. There are, of course, complications also in the treatment of this disease with surgery. Persistent hyperthyroidism and myxedema both can occur after surgery as well as after radioactive iodine.

In addition, surgery has some hazards of its own—laryngeal nerve damage, parathyroid damage, and complications having to do with the wound such as hemorrhage, persistent disfiguring scars, skin dimpling (where the drain was placed), and so forth.

Hypothyroidism is not per se a surgical problem; it should be treated with thyroid hormone in one form or another.

B. Increase in size.

Increase in size warrants surgery, if any of the following symptoms are produced: dysphagia, dyspnea, or cosmetic deformity. Pressure symptoms are of course more common, and occur earlier, with nodules located at the thoracic inlet, where room for expansion is quite limited.

C. Thyroiditis.

Corticoids are most often used in the treatment of subacute thyroiditis, and dessicated thyroid or thyroxine for Hashimoto's disease[3]; surgery is used only secondarily for pressure symptoms, and then used reluctantly.

D. Carcinoma.

A detailed outline of the treatment of carcinoma of the thyroid does not fall within the scope of this article. Suffice it to say that differences of opinion still exist between the proponents of limited and extensive resections.

Changing Times

Is thyroid surgery vanishing?

It had been our impression that thyrotoxic patients were rarely arriving at the surgical threshold nowadays, and we were interested to see if this would be borne out by the facts. To contrast the modes of therapy of thyroid disease before and after the advent of radioactive iodine, we examined the files of the Louisville General Hospital for 1941 and 1961.

In Fig. 2 we see listed for 1941 on the surgical service a total of 26 thyroid operations: Sub-

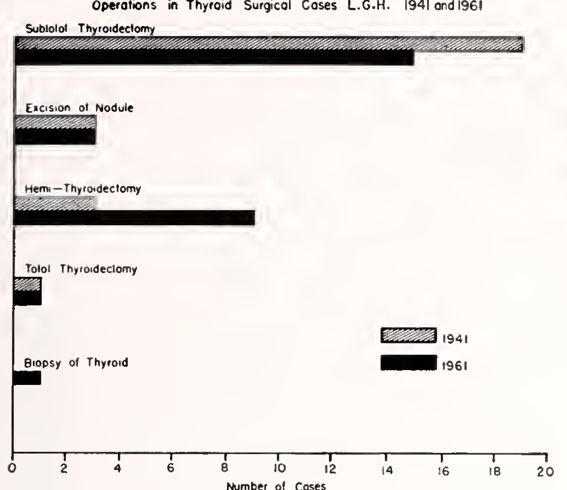

Figure 2.

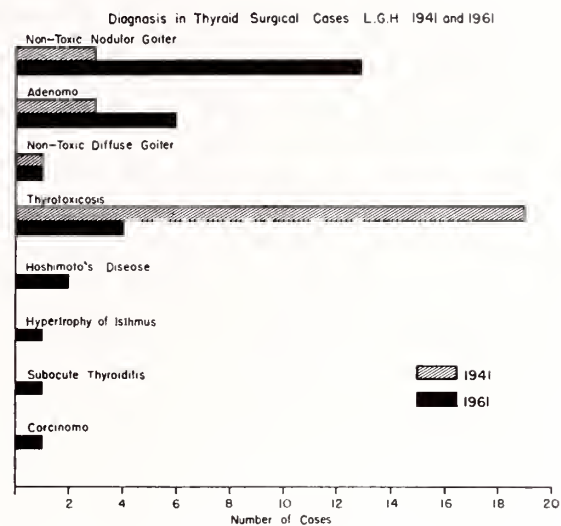

Figure 3.

total thyroidectomy 19, excision of nodule 3, hemi-thyroidectomy 3, and total thyroidectomy 1. Thyrotoxicosis was the reason for operation in 19, adenoma 3, non-toxic nodular goiter 3, non-toxic diffuse goiter 1.

In 1961, in comparison, 29 operations: Subtotal thyroidectomy 15, hemithyroidectomy 9, nodule excision 3, biopsy of gland 1, and total thyroidectomy 1. Nodular goiter was the cause of operation for 13, adenoma 6, thyrotoxicosis 4, Hashimoto's 2, diffuse non-toxic goiter 1, hypertrophy of isthmus 1, subacute thyroiditis 1 and cancer 1. (This is of interest: 1 carcinoma in a year.)

What can we deduce from this? It is interesting to note that the total number of thyroid operations has remained essentially the same. Thyrotoxicosis accounted for 19 of the operations in 1941 and only 4 in 1961. What took up the slack? Where are the operations coming from? The major change is the increased frequency of benign nodular goiters. We would infer from this that these are primarily patients who clinically had single nodules felt, who were then operated on, and as so many times is the case, had multiple nodules found; the pathological signout diagnosis was nodular goiter.

What then is bringing patients to surgery, what is giving surgical residents their training? It's not thyrotoxicosis, for reasons we have mentioned, but the nodular goiter and primarily the single nodule. It's of interest that the overall incidence of thyrotoxicosis is apparently unchanged; in 1941 in the whole hospital (not just on the surgical service) there were 24 admissions for thyrotoxicosis, and in 1961 there were 23. In 1941, however, 19 of 24 were operated upon, and in 1961 only 4 of 23.

Conclusions

(1) The indications for surgery in thyroid disease include a single thyroid nodule, excessive glandular size with symptoms or cosmetic defects, nodular toxic goiter, and thyrotoxicosis in the otherwise uncomplicated individual under the age of 40.

(2) The lower age limit for the use of radioactive iodine is likely to decrease constantly; many physicians are now using radioactive iodine treatment in hyperthyroid patients under the age of 40.

(3) The pattern of thyroid surgery is changing, with operations on nodular glands apparently increasing in number just about as rapidly as operations for control of thyrotoxicosis decrease.

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Present Approach to Immunization for Poliomyelitis*

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The advantages and disadvantages of the Salk and Sabin vaccines are discussed, including a review of the information recently released by the Surgeon General regarding the use of the Type III oral (Sabin) vaccine.

AT THE present time there are still many questions regarding the best approach to polio immunization. Two major factors contribute to this uncertainty: first, the availability of several different vaccines, and secondly, the occurrence of failures or complications associated with their use. Although both the killed virus vaccine (Salk) and the attenuated live vaccine (Sabin) can prevent the paralyzing effects of poliomyelitis, there are important differences which should be clearly understood.

Salk Vaccine

The killed virus vaccine (Salk) has been used widely in the United States, and its effectiveness in now apparent. The annual incidence of reported cases of poliomyelitis (including both paralytic and non-paralytic) in the United States dropped from 28,985 in 1955 to 1,312 in 1961. During this same period, the number of paralytic cases decreased from 13,850 to 988.[1] This marked decline in paralytic cases can be attributed primarily to the use of the inactivated polio vaccine (Salk) during this time.

In addition to its known effectiveness, an important advantage of the Salk vaccine is the apparent safety of the present commercial product. It has been estimated[1] that more than 50 million persons in the United States had received four or more doses of the inactivated vaccine by September 1961. There have been essentially no complications except with the very early batches which were contaminated with live virus.

One disadvantage, however, is that paralytic cases have continued to occur. Small epidemics (particularly with Type III virus) have been reported, such as the outbreak in Massachusetts in 1959[2] in which almost half of the paralytic cases had received 3 or more injections of Salk vaccine. Why should paralytic cases continue to occur in areas where a large proportion of the population have been immunized with Salk vaccine? One explanation may be found in the fact that a significant number of persons still lack neutralizing antibodies to poliovirus (especially to Type III) after a course of 3 injections of commercially prepared vaccine.[2-4] Infants respond less well than older persons particularly if immunizations are given to those under three months of age.[3]

Brown and Napier[5] found no antibody titer for Type III in 30% of a group of children who had received 4 injections; 23% had no antibody titer to Type I and 6% demonstrated none to Type II. Horstmann, et. al.[6] reported similar serologic findings after 4 injections of Salk vaccine, no antibodies were demonstrated in 37% to Type III and in 15% to both Types I and II.

A recent report by Lepow, et. al.[4] shows that almost half of the children immunized with commercially prepared Salk vaccine had no demonstrable antibodies to Type III one year following their third dose, and approximately one quarter had no antibodies to Type III two years after their fourth dose.

Although Salk[7-8] has shown that the absence of detectable serum neutralizing antibodies does not necessarily indicate total lack of immunity, it appeared to have clinical implications in the Massachusetts epidemic.

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These data suggest a need for a more potent commercially prepared killed virus vaccine especially for Type III polio virus. Because of the apparent variation in potency in commercially prepared vaccines and since long-term follow up studies have only recently became available, the exact number and frequency of booster immunizations of the killed virus vaccine remains uncertain.

The present recommendation of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics[9] suggests the following schedule for infants:—Three initial immunizations of killed virus vaccine (containing all 3 types) at monthly intervals starting at 2 months of age; administration of the fourth immunization is recommended 8 months later (at one year of age). Boosters are then suggested every 2 years. The availability in the future of more potent products may well change the recommendation for the interval and number of booster immunizations.

Gastrointestinal Immunity

Although the killed virus vaccine produces immunity to paralysis from poliomyelitis in the majority of cases, it does not influence the development of gastrointestinal immunity to the polio viruses. The Salk vaccine reduces the incidence of paralytic disease through serum antibody production but does not prevent multiplication of polio viruses in the intestinal tract. Thus in a community with a large percentage of the population protected by Salk vaccine, polio viruses can maintain a continuous cycle of transmission and can paralyze those who have never acquired immunity or those who have lost it. Thus epidemics have continued to occur in the United States, Canada, Hungary, and Israel, where killed virus vaccine has been administered to the major portion of the susceptible population.

Although better vaccines are now being prepared, and better results will be expected with their use in an increasing proportion of the population, the killed virus vaccine administered by injection will never have the potential of eliminating the wild viruses from the community.

Sabin Vaccine

The oral (Sabin) vaccine utilizing attenuated live viruses is now commercially available and is being used in mass immunization programs throughout the United States because it appears to present certain significant advantages over the killed virus vaccine. The first of these is the ease of administration which in some parts of the world has allowed for the immunization of an extremely high proportion of the population. The response in this country during the past few months would suggest equally good acceptance in the United States.

Secondly, the oral vaccine is apparently quite effective in producing serum immunity as measured by the antibody response (although long term studies are not available to determine the duration of effectiveness). The initial immunization with one dose of each type of polio virus would appear to confer immunity in a very high percentage of the population to all 3 types.[10-11] Early studies by Sabin, et. al.[10] in Cincinnati showed that 100% of those immunized developed antibody response to all 3 types. In Czechoslovakia[11] (where the majority of the population was immunized) antibodies developed to Type I in 95%, to Type II in 93%, and to Type III in 94% of those receiving vaccine.

An immunization program conducted by Sabin and others in Mexico[12] revealed that less good immunity developed to oral polio virus vaccine under conditions of massive infection of the population with other enteric viruses. Antibodies were demonstrated in this group in only 68%, 82%, and 43% respectively to Types I, II, and III, following a single dose of trivalent vaccine. However, after a second trivalent dose, the conversion rate was raised to 96%, 96%, and 72% respectively.

Other enteric viruses in the gastrointestinal tract apparently compete with or interfere with the polio viruses. Therefore, it has been recommended that mass immunization to poliomyelitis with the oral vaccine be carried out in the winter and spring months when the incidence of other enteric viruses in the population is at its lowest. Interference between the polio viruses themselves accounts for the recommendation that each type be given separately and at intervals of approximately six weeks.

The most important advantage of the live oral vaccine over the killed virus vaccine is its ability to produce intestinal immunity. Because of this fact, it seems possible that the wild paralytic strains of poliomyelitis can be eliminated entirely from an immunized community.

An infectious disease can be eliminated when the chain of transmission necessary for the survival of the infectious agent is broken. Since the alimentary tract is the primary site for multiplication of the polio viruses, the wild viruses are maintained in nature in contaminated feces.

The present evidence would indicate that immunization of 70% to 80% of the population with attenuated virus is sufficent to break the chain and eradicate the disease entirely. However, in order to achieve this goal, mass immunization is necessary. This is the reason for the present emphasis on community programs.

Experience with oral vaccine in the United States is still limited, but it has been widely used in other parts of the world. Although the follow-up is short, it would apear that poliomyelitis has essentially been eliminated from countries such as Czechoslovakia[11] and other areas of eastern Europe where the majority of the population has been immunized.

Possible Defects of Sabin Vaccine

Fear of possible undesirable side effects has influenced the use of the oral vaccine in the United States. First, the fact that the attenuated oral vaccine, like the killed vaccine, is prepared from monkey tissue has raised concern about the possible presence of other simian viruses in the vaccine. A number of new simian viruses have been identified but their pathogenicity for man has not been demonstrated. The use of formalin in the Salk vaccine has been regarded as a safety factor in the killed virus vaccine. However, at least one recently discovered new simian virus (vacuolating agent) has been shown to be resistant to formaldehyde, but when swallowed it does not appear to propogate or penetrate tissues. This would suggest that the oral route may in fact be a safer method of administration as far as certain simian viruses are concerned. To date, there have been no known illnesses or other complications attributed to the use of monkey tissue in the preparation of either type of vaccine.

Secondly, the possibility that the attenuated viruses could on occasion produce paralytic disease or perhaps revert to a wild paralytogenic strain after passage through humans was a matter of some concern. However, in the study conducted by Sabin and others[10] in Cincinnati, all cases of possible poliomyelitis that could have been attributed to the vaccine were carefully studied and in no instance was a case of paralytic poliomyelitis related to the vaccination either in those immunized or in their contacts. In addition, there was no evidence of change in the virulence of the virus for monkeys after its passage through humans in the community. Furthermore, the dissemination of the attenuated virus in the community was limited to approximately three months, although initially there was evidence of spread of the attenuated virus to non-immunized contacts.

Study Confirms Safety

Initial studies of small population groups in other parts of the United States tended to confirm the safety of all three types of oral vaccine. Extensive use of the Sabin vaccine in other parts of the world in over a 100 million people seemed to indicate that fear of undesirable side effects was unfounded. With this evidence for the value and safety of the oral vaccines, a great many community-wide vaccination programs have been carried out in the United States since August 17, 1961, when the first oral vaccine (Type I) was licensed for distribution.

Since this time the poliomyelitis surveillance program of the Communicable Disease Center has placed particular importance on the evaluation of reported cases of poliomyelitis developing after the use of the oral vaccine. If the vaccine is related to the development of symptoms, the onset of the disease would be expected within seven to thirty days following the administration to the vaccine. In September 1962 the Surgeon General reported[1] that a total of 62 cases of possible poliomyelitis had been officially reported to the Public Health Service following administration of oral polio vaccine.

Of these 62 cases, however, only 12 (one following Type I vaccine, and 11 following Type III vaccine) were considered by the Surgeon General's Oral Poliomyelitis Vaccine Advisory Committee to be clinically consistent with paralytic poliomyelitis and with laboratory findings which could not exclude a possible relationship with the administration of oral vaccine.

The single case that occurred within thirty days of the administration of Type I vaccine when approximately 20 million persons had been fed Type I was considered to be compati-

ble with coincidental occurrence.

The occurence of 11 cases of paralytic disease within 30 days of administration of Type III vaccine could not be assumed to be entirely coincidental. These cases occurred two to three weeks following the vaccine and were all in adults between 16 and 52 years of age. From six of the eleven cases, Type III polio virus was recovered from stool specimens. Five of the six were characterized as vaccine-like by the modified Wecker and McBride tests which are used to differentiate vaccine viruses from wild viruses.

It has been estimated that approximately 13 million doses of oral Type III vaccine had been fed at that time. If it is assumed that all 11 cases were vaccine induced, this represents less than one case per million doses given. Since all cases were in adults, it seemed that the risk, if any, was greater in adults than in children.

On the basis of this data, the Surgeon General's Oral Poliomyelitis Vaccine Advisory Committee recommended on September 15, 1962 that mass programs be continued for all age groups for Type I and Type II oral vaccine. Because of the possible risk to adults with Type III, the committee recommended that "Type III vaccine be restricted to pre-school and school age children and to those adults in high risk groups such as those traveling to hyperendemic areas or in areas where a Type III epidemic is present or impending."

However, in December of 1962 the Special Advisory Committee revised their recommendations[11] after further review of the previously reported cases and evaluation of an additional 25 cases of polio-like illness known to be associated with the administration of oral vaccine. The committee reported that there were still only 11 cases considered to be "compatible" with being vaccine-induced following the administration of 15 million doses of Type III, and 7 cases considered as "compatible" with the 31 million doses of Type I that had been given during 1962. No Type II cases were considered as being possibly induced by the vaccine.

On the basis of these newer data the committee recommended and encouraged the continuation of community plans for immunization using all three types of oral polio vaccine. They suggested that special emphasis be given to immunization of children and young adults (especially parents of young children, pregnant women, persons in epidemic situations, and those planning foreign travel). They suggested that vaccination of adults (particularly above the age of thirty) should be carried out only with the full recognition of its very small "risk." The report estimated the maximum "potential risk" for Types I and III to be of the order of one per million or less over-all, but higher for those over 30 years of age.

In a recent review of these statistics Sabin[12] suggests that an incidence of this type may represent no potential risk at all in view of the fact that the cases of paralytic disease occured only in a few localities and since a certain number of cases of polio-like illness are bound to occur from various other viruses and non-viral causes in any large population group. Therefore, many communities have proceeded with their immunization programs for all 3 types. In addition, individual physicians are encouraged to include the oral polio virus vaccine in their regular immunization program for infants and children. Immunization of children with all three types is now recommended by the American Academy of Pediatrics.[13]

Since the major advantage of the oral vaccine is associated with mass immunization, this necessitates a community-wide effort involving the cooperation of the county medical societies and the Health Department. Many communities have now demonstrated that mass programs can be carried out efficiently and these have had wide acceptance among the population. It is recommended that such immunization programs in the United States be carried out during the winter and spring months whenever possible and that separate doses of each of the three types be given at approximately six week intervals. Three drops of vaccine are placed on a lump of sugar and taken orally. The interval at which boosters are needed has not yet been determined. When a safe commercially prepared trivalent vaccine becomes available it will probably be recommended that this be given as a booster in populations in which the incidence of enteric viruses may be high (such as in institutions) or during the summer months. The same recommendation will probably also be made for infants who produce immunity less well than older children.

The oral method of immunization would appear to present the very rewarding possibility of the total eradication of poliomyelitis.

(Continued on page 539)

Cushing's Syndrome Due to Adrenocortical Adenoma†

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Moon facies, hypertension, and muscle weakness in a thirty-four-year-old slender woman were caused by adrenal cortical adenoma. This case, some new available methods of differentiation, and the possibility of future medical therapy for cortical hyperplasia are discussed.

HARVEY Cushing would be gratified by the progress of medical research in the many facets of the syndrome which bears his name. However, each uncovered fact raises new questions for those in research and clinical practice.

The classical Cushing's syndrome patient with truncal obesity, florid countenance, hypertensive heart failure, purple striae, osteoporosis and diabetes has long been a familiar textbook feature. Today more precise methods of study permit earlier recognition and treatment and an improved salvage rate.

Plotz et al.[1], in a 1952 review of the natural history of Cushing's syndrome, noted that seventeen of thirty-four patients were dead within five years following diagnosis. The increased mortality, difficulty of surgical technique and moribdity of the long-standing obese Cushing's syndrome patient with added hazards of hypertension, friable tissue and diabetes make early diagnosis and treatment highly desirable. In early reviews patients usually died of over-whelming infection; recently, cardiovascular, cerebrovascular, osteoporotic and psychiatric complications have been frequent.

The clinical picture is variable. However, central obesity, weakness, hypertension, protein wasting, impaired glucose tolerance and elevated 17-hydroxysteroid plasma or urinary excretion levels are usually found. Cushing's syndrome is three times more frequent in females and is more common in the thirty to fifty age group.[1, 2, 3]

Differentiation between reactive physiological hypersecretion, bilateral adrenocortical hyperfunction or hyperplasia, benign adenoma, and carcinoma is now possible in most instances by the method of Liddle and associates.[4]

There is a rather selective behavior of these entities with dexamethasone or 9-alpha fluorocortisone suppression of ACTH as ascertained by the twenty-four hour urinary 17-hydroxysteroid excretion. The neoplastic adrenals do not suppress except in very rare instances. The reactive hypersecretion states suppress with 0.5 mg. dexamethasone every six hours for twenty-four hours. Adrenal hyperplasia (hyperfunction in some reviews) is suppressed with rare exception by 2 mg. dexamethasone every six hours for twenty-four hours. Scott and Liddle[5] report failure of suppression of hyperplasia in only one of twenty-four cases. Sprague et al.[6] report two cases of failure of suppression of hyperplasia. Adrenal cortical carcinoma usually produces autonomously elevated 17-hydroxy- and 17-ketosteroids. Often, by the time Cushing's syndrome is clinically apparent, adrenal carcinoma is palpable.

Case Report

The case to be described was investigated following a blood pressure determination at the time of an office visit for a minor menstrual ir-

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regularity. The patient was thirty-four years of age, white and weighed 129 pounds. She was an IBM calculator operator.

A mild respiratory infection was present. Questioning disclosed fatigue and irritability associated, especially with weakness of the back muscles in the mid-afternoon. She had increased her smoking to one and one-half packages of cigarettes daily and coffee consumption to twelve cups per day in an effort to overcome this weakness. Frequent startle reactions and labile emotional responses to previously well tolerated stress were noted. Nocturnal leg cramps had been present several months. Intermittent hoarseness was present several weeks. Upper chest pain on deep inspiration had occurred occasionally at night. Ankle edema occurred initially two weeks prior to examination. Intolerance to recent summer heat was marked. Occasional left fifth finger paresthesia was noted. Her weight had previously been stable at 125 pounds. Her relatives, noting facial fullness, had mentioned weight gain three years previous to diagnosis.

Past History

The past history included a dilatation and curettage two years previously for spotting, menarche age twelve years, generally regular menses, marriage seven years, gravida 0. There had been multiple dental extractions.

The patient's father died of heart disease at age 59. The mother, who was three years post surgery for craniopharyngioma had late onset diabetes. Three siblings were in good health and a fourth was hypertensive.

On physical examination she was a thirty-four year old attractive, intelligent, white female, five feet, five inches tall, weighing 129 pounds. Her temperature was 99 degrees. Moderate moon facies and moderate exophthalmus were present. The thyroid gland was symmetrically enlarged to twice normal size. Only a slight increase in the thoracic fat pad was noted. Normal female escutcheon was present. The abdomen was free of masses or striae. The right kidney was palpable. The blood pressure was stable at 160/110-100. A systolic grade II murmur was heard along the left sternal border. Pelvic, rectal and neurological examinations were normal except for anesthesia of the left ulnar dermatome.

When ambulatory, there was a striking erythema and multiple superficial varicosities of the legs which partially cleared on bed rest. A roentgenogram of the chest demonstrated maximal normal cardiac size. Intravenous pyelograms, skull x-rays and visual fields were normal. The electrocardiogram demonstrated minimal changes of left ventricular hypertrophy. Dental x-rays were consistent with absorption of the lamina dura. The carbon dioxide content, potassium, sodium, chloride, protein bound iodine, calcium, phosphorus, cholesterol, blood sugar, oral glucose tolerance test and urinalysis were normal. A repeat oral glucose tolerance test demonstrated a flat curve.

Blood Count Up

The blood eosinophil count was 283 cu. mm. This may have been influenced by a reaction to penicillin. Subsequent depression was noted during Florinef® administration. Although the hemoglobin of 14 grams and hematocrit of 43 volumes percent were not unusual, the white blood count was consistently elevated, ranging from 18,000 to 26,000 per cu. mm. The differential counts were normal. Athens et al.[7] of Dr. Wintrobe's laboratory report inducing a 75 percent increase in the circulating granulocyte pool after eight days by giving 4 mg. prednisone daily. Similar findings with ACTH[8] and increase of marrow myelocyte-erythrocyte ratio[9] have been demonstrated.

Failure of Suppression

Initial twenty-four hour excretions of 17-hydroxysteroids were 19 and 16.9 mg. per twenty-four hours. The normal levels for females by the Porter-Silber method in the Louisville Methodist Evangelical Hospital Laboratory is 3 to 12 mg. per twenty-four hours. The twenty-four hour 17-ketosteroid determination was not elevated.

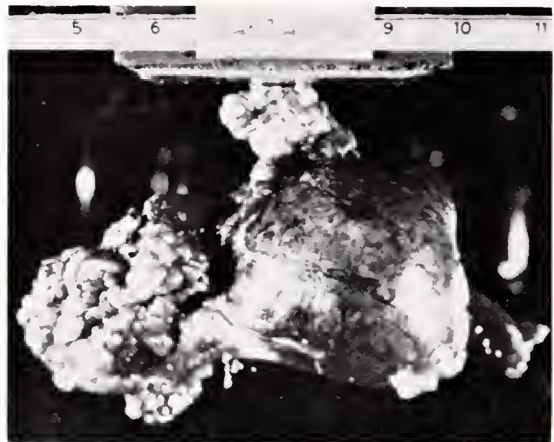
Pre-medication with 0.5 mg. 9-alpha fluorocortisone every six hours for twenty-four hours failed to suppress 17-hydroxycorticosteroid levels on two occasions; excretion totaled 23 and 24.2 mg. per twenty-four hours.

Failure of suppression also occurred with 2 mg. 9-alpha fluorocortisone every six hours for twenty-four hours. By Liddle's criteria it appeared at this point that a functioning adrenal cortical adenoma was present.

Normal serum potassium and carbon dioxide levels indicated that hyperaldosteronism was not a significant problem. Consequently, aldoste-

rone excretion studies were not done.

The patient slipped while walking in her room, sustaining a torus type minimal fracture of the pubic and ischial rami after a fall of only two and one half to three feet. Orthopedic consultants were willing to accept this as indirect evidence of osteoporosis. Therapy consisted of bed rest affording time for confirmatory studies.



Scale in centimeters

Fig. 1. Adrenal adenoma. Exterior view.

Administration of ACTH over the short interval of two hours produced no further elevation of 17-hydroxysteroid excretion. 17-ketosteroid excretion rose moderately to 15.5 mg. during the first twenty-four hours. Ketogenic steroid determinations were elevated as confirmatory studies.

The anterior surgical aproach was elected. Adherents of two stage lumbar and double lumbar procedures are numerous. Horwith and Stokes[2] note that the anterior approach is preferred in severely osteoporotic patients. They also observe that inspection of one gland by lumbar approach often fails to provide sufficient information to make the correct decision for gland removal or closure, especially in cases of normoplastic bilateral adrenocortical hyperfunction. The anterior approach permits more accurate appraisal but is often associated with greater morbidity.[2, 3, 5, 6, 10] Bilateral hyperplasia (or sustained hyperfunction) occurs about six times more frequently than functioning cortical adenoma in Cushing's syndrome. Functioning adenoma is usually found twice as often as carcinoma. In Scott and Liddle's series all six functioning adenomas were located in the left adrenal gland.

Pre-medication with potassium chloride and calcium lactate relieved restless leg cramps. Cortisone acetate 100 mg. intramuscularly was given the morning of surgery. Both adrenal glands were explored and a splenectomy was done. A total of 150 mg. hydrocortisone intravenously and 400 mg. cortisone intramuscularly were given during the day of surgery. Shock observed twelve hours following surgery was controlled by a single infusion of noradrenalin together with whole blood. Left lower lobe atelectasis occurred as is frequently found. She required more potassium replacement than is the experience of others. Cortisone was tapered rapidly in 100 mgm. daily increments.

The left adrenal tumor weighed twenty seven grams. Atrophic gland was present inferiorly. A benign nature was assumed by the complete encapsulation (Fig. 1 and 2). Microscopic study was characteristic of adrenal cortical adenoma (Fig. 3).

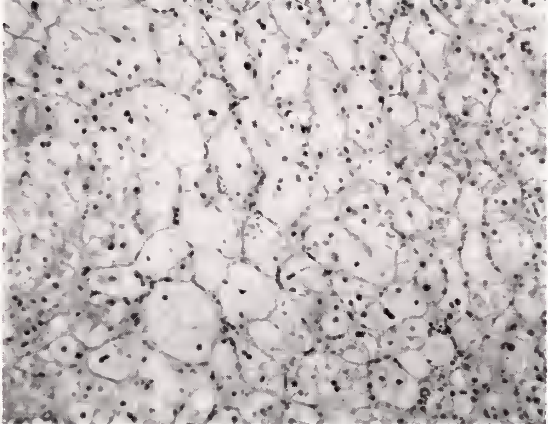
Oral hydrocortisone withdrawal regimen was utilized without use of ACTH. Initially, rather disabling withdrawal symptoms occurred below dosage of 20 mg. hydrocortisone daily. Anorexia, nausea, weakness, myalgia and arthralgia responded to modest increase in the hydrocortisone dosage. A small draining sinus healed in two and one-half weeks. Wound healing was excellent. Gradual weaning from supplementary hydrocortisone was done over a period of approximately twelve months. She was permitted to return to work three months postoperatively. The weight stabilized at 112 pounds, the systolic blood pressure at 106 to 120 mm. Hg. and the diastolic pressure at 80 mm. Hg. The leukocyte counts have ranged from 9,000 to 16,000 per cu. mm.

Four and one-half months following adrenalectomy, five periapically abscessed teeth were removed uneventfully. Cortisone acetate 100 mg. intramuscularly before and following extraction with antibiotic support was utilized. The moon facies and exophthalmus have diminished. The thyroid gland remains enlarged. Sixteen months following left adrenalectomy 24-hour urine 17 hydroxysteroid excretion was 4.8 mgm.

Discussion

Sprague,[6] Nabarro[11] and others have discouraged the use of chemical and radiological efforts to identify specifically the location in the hypothalamus-pituitary-adrenal axis of the pathology producing Cushing's syndrome in an

Fig. 2. Cut surface of encapsulated tumor and inferior remnant of adrenal gland.



Scale in centimeters

Fig. 3. Adrenal adenoma. Microscopic section demonstrating lipid laden cortical type cells. x 170.

individual patient. Their point is that surgery is necessary in either case.

Amphenone, Su-4885[12] an analogue of amphenone B, OP'DDD*[13], and Triparanol **[14] have been shown to suppress cortisone synthesis. All prementioned drugs have toxic side effects of different nature in the dosage required. However, suppression of cortisone production even in functioning adrenal carcinoma has been obtained. Modification of these or other compounds holds promise in the future for control of Cushing's syndrome due to bilateral adrenocortical hyperfunction. Since the present treatment for bilateral hyperfunction produces Addison's disease or the insecurity of probable Addison's disease, every effort should be made to perfect identifying procedures as well as specific therapeutic compounds.

At present surgical therapy can be more intelligently planned if the surgeon knows beforehand what he is likely to encounter within a 90 to 95 percent degree of accuracy. Many surgical procedures are undertaken for less lethal conditions under less precise preoperative diagnosis.

Summary

A thirty-four year old female presented with moon facies, hypertension, weakness and elevated 17-hydroxysteroid excretion. Failure of potent steroid suppression of 17-hydroxysteroid urine excretion fulfilled Liddle's criteria for a presumptive preoperative diagnosis of functioning adrenal cortical neoplasm. Lack of a palpable tumor and normal 17-ketosteroid excretion favored adenoma. A 27 gram left adrenal cortical adenoma with atrophy of remaining adrenal tissue was found. Clinical details of this case and some of the associated problems of diagnosis and management are discussed.

* *2,2-Bis (2 Chlorophenyl-4 chlorophenyl)-1, 1-dichloroethane*

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Coexisting Pulmonary Fungous Infection and Tuberculosis at District Two State Hospital

Oren A. Beatty, M.D.*, and Alex Saliba, M.D.**
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Pulmonary histoplasmosis and tuberculosis co-exist in 19% or more of the cases. Active or latent tuberculosis is more easily diagnosed in association with pulmonary histoplasmosis than is histoplasmosis in active pulmonary tuberculosis.

THE co-existence of fungous disease and tuberculosis has not been fully investigated in all its aspects. It has long been known that there is a widespread incidence of both infections as demonstrated by the histoplasmin and tuberculin skin tests. As previously reported (1) almost 12% of the routine admissions to this hospital had positive serologies for histoplasmosis and 52% of 100 random cases of tuberculosis reacted positively to histoplasmin. In 293 sanatorium admissions (2) reported to the State Department of Health, 90% had positive tuberculin and 28% had positive histoplasmin skin tests. A study of a mixed group of all ages in Webster County showed 23.5% positive tuberculin reactors and 55.5% positive histoplasmin reactors. Timmerman et al (3) reports the survey of Kokko et al (4) in which they found a histoplasmin reactor rate of 69% in Livingston and Marshall Counties.

Since co-existing infection is rather prevalent one would conclude that co-existing active disease may not be rare. Skin test surveys have shown two to three times as much infection with histoplasmosis as with tuberculosis, however active tuberculosis is much more frequent than active histoplasmosis. Since the incidence of histoplasmosis disease is much less than the incidence of tuberculous disease this probably means that histoplasmosis is more benign as an infection. On the other hand the benign nature of histoplasmosis may make it more difficult to demonstrate histoplasmosis infection in patients with active tuberculosis. It is none the less deserving of attention as it has been shown to be a progressing disease and in untreated cases its morbidity and mortality can be significant.

We have observed co-existing active tuberculosis and active histoplasmosis, active histoplasmosis and latent tuberculosis, and active tuberculosis with latent histoplasmosis. Latent tuberculosis has been recognized not only by positive tuberculin skin test but also by recovery of mycobacteria during the period of observation. Latent histoplasmosis has been recognized only by positive histoplasmin skin tests and positive serology. At no time have the organisms of Histoplasma capsulatum as a latent infection been isolated from an active case of tuberculosis. On the other hand, in four cases of active histoplasmosis, mycobacterium tuberculosis, human type, cultured out on one occasion in each case and was not found in subsequent cultures.

Material

Thirty two cases of active pulmonary histoplasmosis have been diagnosed either by identifying the organisms in sputum cultures or in tissue (Table 1). Two of these had co-existing active tuberculosis confirmed by positive sputum smears and cultures. Four had a single culture of Mycobacterium tuberculosis, human type, isolated later in the course of observation. Two had a single atypical form of mycobacterium isolated by culture late in the course of observation. One of these was identified as Mycobacterium fortuitum and the other apparently was lost before identification during the

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Co-existing Pulmonary Fungous Infection and Tuberculosis*
At District Two State TB Hospital, Louisville, Ky.

Case #	Histoplasma Capsulatum demonstrated Sputum	Histoplasma Capsulatum demonstrated Tissue	Tubercle Bacilli On Adm.	Tubercle Bacilli Single Culture Isolated later Typical	Tubercle Bacilli Single Culture Isolated later Atypical	Tubercle Bacilli One + Smear & negative culture
8632	x	x				
8456	x			x		
3982	x					
3071		x				
1843		x				
9739		x				
9489	x					
9945	x					
5716	x		x			
9922	x					
9665	x		x			
8785	x			x		
8012	x					
8108	x					
6753		x				x
6884	x					
6944		x				x
7217	x	x				
7240		x			x	
1779	x					
6582	x					
8647		x				
9082	x	x		x		
5135	x					
5312		x				
5500	x				x	
5895	x	x		x		
6576	x					
7501		x				
7523	x					
7590	x					
7627	x					
TOTAL	23	13	2	4	2	2
% of 32 cases			6¼	12½	6¼	6¼

Table 1 Pulmonary Histoplasmosis and Tuberculosis.

moving of the State Board of Health Laboratory from Louisville to Frankfort. In two patients acid-fast organisms were found in a single smear but these failed to grow out in culture.

Co-existing disease occurred in 6.25% and co-existing infection in another 12.5%. If the two patients showing atypical organisms and the two showing positive smears are included, co-existence occurred in 31%.

Eight cases of pulmonary aspergillosis have been observed and diagnosed by consistently isolating the organisms from the sputum or identifying them by histopathology (Table 2). Upon admission four patients had active tuberculosis confirmed by positive cultures. In one, the aspergillus culture was obtained from the cavity after resection. In two others the aspergillus was identified by histopathology. In three cases the aspergillus infection occurred without active tuberculosis. In one patient two positive smears for AFB were reported in 1952 but these were not cultured.

Discussion

In most tuberculosis hospitals where an active case finding program for histoplasmosis is carried out, the examination of the sputum by smear, concentrate and culture for tubercle bacilli is done routinely throughout the hospitalization. This provides an adequate search for and satisfactory knowledge of the presence of active tuberculous disease or possibly latent infection.

However when active pulmonary tuberculosis is diagnosed, there is a tendency to forget that another disease or infection may also be present. If a positive complement fixation for histoplasmosis is found, six sputum specimens may be cultured but repeated examinations are seldom carried out. In areas of high incidence of histoplasmosis, complement fixations should be done routinely and a continuous search for the organisms in positive reactors carried out. In the presence of active tuberculosis with susceptible organisms, which does not respond satisfactorily radiologically and clinically to treatment, a search for Histoplasma capsulatum should be made.

In one of the two patients who had active coexisting disease, a laryngitis was present which was considered tuberculous upon admission. The diagnosis of pulmonary tuberculosis was readily established and the patient was started on anti-tuberculous chemotherapy. The laryngitis improved but the hoarseness persisted for months. When the diagnosis of pulmonary histoplasmosis was later established the patient rejected therapy for this. A biopsy of the larynx failed to show either acid-fast organisms or Histoplasma capsulatum.

Except in the presence of co-existing active disease, it is not always apparent how tubercle bacilli get into the sputum of active cases of histoplasmosis. It is reasonable to believe that a destructive fungal disease may erode inactive lesions and liberate dormant tubercle bacilli which can be found in sputum if adequate examination is carried out. These are not likely to cause active disease except under the proper environment and favorable circumstances. Like-

*These cases are included in the Cooperative Therapy Trials for the Mycoses at CDC, Kansas City.

Co-existing Pulmonary Fungous Infection and Tuberculosis
At District Two State TB Hospital, Louisvile, Ky.

Case #	Aspergillus Demonstrated Sputum	Aspergillus Demonstrated Tissue	Tubercle Bacilli On Adm.	Tubercle Bacilli Positive smear & negative culture
9133	x		1 + culture on adm.	
8086	x		—	
7030	x	x		
7039	x taken from cavity		x	
6233		x	x	
4497	x			2 + 1952 and not cultured
2159		x		
1367		x	x	
TOTAL	5	4	4	1

Table 2 Pulmonary Aspergillosis and Tuberculosis

wise active tuberculosis may perhaps erode into healed histoplasmosis and liberate the organisms. Because of either inadequate examinations or the lack of proper techniques these organisms have not been found as yet in such cases. Their identification may await the development of other techniques, including fluorescent antibody scanning. Sweany et al (5) has pointed out the difficulty in culturing and identifying H. capsulatum with our present knowledge and technical methods. He stated the chief reason for failure is the presence of inactive pathogens. If this is true in the active case it must be more difficult in the latent or inactive cases.

Since histoplasmin skin sensitivity reactions in Kentucky show the incidence of infection to be two to three times that of tuberculosis, many latent fungal infections should be demonstrated in active cases of tuberculosis unless only inactive pathogens are present. In the cases of histoplasmosis it is not surprising to find 6.25% co-existing tuberculosis, but it is surprising to find 31% co-existing infection. This approximates the incidence of tuberculous infection in the general population. This high rate of co-existence would tempt one to discount the two patients with positive smears and the two with atypical cultures as having saprophytic invaders. If such is true the co-existing disease rate in this small group would be 6.25% with an additional 12.5% co-existing infection. The rate of 19% appears more realistic. However Sweany et al (6) reported 31.7% co-existing infections exclusive of two Runyon Group IV cases.

The saprophytic nature of certain acid-fast organisms has been known for a long time. Huppert et al (7) re-emphasized the possibility of acid-fast bacilli obtained from sputum being saprophytic mycobacteria. Therefore it may be that these atypical organisms and positive smears were saprophytes.

The problem of pulmonary aspergillosis appears to be altogether different from that of pulmonary histoplasmosis. Very likely it is a secondary invader following tuberculosis or some other pulmonary disorder in most cases.

Summary

Thirty two cases of active pulmonary histoplasmosis are reported with two cases of co-existing active tuberculosis and with four cases of co-existing infection. Bacteriological evidence of other acid-fast organisms which may be saprophytes are also reported. Attention is called to the fact that no mycological evidence of co-existing infection in active cases of tuberculosis has been found. A more aggressive and continuous search for Histoplasma capsulatum should be made in these cases.

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Treatment of Chronic Emphysematous Bronchitis †

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Louisville, Ky.

This paper gives briefly statements concerning the definition and diagnosis of the disease and some of the causative factors. A program of practical treatment is outlined.

THE RELATIONSHIP between chronic bronchitis and pulmonary emphysema has long been recognized. In a text book titled "Diseases of the Lung" by Babcock, published in 1907, the following paragraph is found: "The changes of chronic bronchial inflammation are almost invarably associated with vesicular emphysema for the reason that whichever process precedes it is quite certain in time to lead to the production of the other." I feel, therefore, that it is quite proper to discuss chronic emphysematous bronchitis as a clinical entity.

We in this country have been reluctant to make the diagnosis of chronic bronchitis, feeling it is a wastebasket type of diagnosis not entirely respectable. However, due to work of British authors and to an increasing awareness of our own of the rising prevalence and importance of this condition, we must conclude that truly this entity is a serious condition commanding the attention of all concerned.

A fairly satisfactory definition of chronic bronchitis has been made by Dr. H. William Harris, Professor of Medicine at Woman's Medical College of Pennsylvania. "A clinical disorder characterized by excessive mucous secretion in the bronchial tree . . . manifested by chronic or recurrent productive cough . . . present on most days for a minimum of three months in the year and for not less than two consecutive years." To make this definition specifically apply to chronic emphysematous bronchitis, there must be added "with symptoms and findings of dyspnea and ventilatory insufficency consistent with pulmonary emphysema."

Causative factors in the production of chronic emphysematous bronchitis consist of prolonged irritation of the bronchial tree with or without infection. Such irritation may be produced by constant inhalation of smoke, dust, smog, irritative fumes and particularly by tobacco smoke. The importance of tobacco smoke as a causative factor cannot be over emphasized. This concept is not new but is recently getting the attention it deserves. To quote Babcock again, "Tobacco smoke is another of the irritants that may conduce to the production of chronic bronchitis. It may seem strange to include tobacco smoke in the category of predisposive causes yet that it does irritate the mucous lining of the trachea and bronchi is shown by the cough so promptly excited when the smoke is inhaled."

I will mention a few points of the relationship of chronic bronchitis to the development of pulmonary emphysema. The percentage of patients with chronic bronchitis who will later develop emphysema is not known. However, according to one report, 68% of a group of emphysema patients had bronchitis three or more years before dyspnea developed, 18% developed bronchitis after the symptoms of dyspnea and only 14% of patients with pulmonary emphysema never developed a chronic cough or expectoration. Pathological studies show evidence of past bronchiolar inflamma-

†*Presented at the meeting of the Kentucky Thoracic Society, at Jenny Wiley State Park, Floyd County, Kentucky, November 15, 1962.*

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tion even in minimal lesions of emphysema, suggesting a casual relationship.

I would like to point out some relationships between smoking and emphysema. From clinical observation a typical emphysema victim is past middle age and has smoked a pack or more cigarettes daily for 20 to 30 years or more. 95% of emphsysema patients have been found to be moderate to heavy smokers while about 64% of normal controls smoked a comparable amount. In a recently reported survey of the prevalence of chronic respiratory diseases approximately 40% of the cigarette smokers had chronic bronchitis with 25% showing irreversible lung disease. This compared with 14% and 7% respectively among those who had never smoked.

Diagnosis

In order to establish a diagnosis of chronic emphysematous bronchitis, it is necessary to rule out other diseases which can cause cough and shortness of breath, such as tuberculosis, congestive heart failure, bronchial asthma, specific infections, foreign body, and pulmonary neoplasm. The cardinal symptoms of chronic emphysematous bronchitis are cough and dyspnea. An adequate history and examination to determine the presence or absence of other disease should be done. Chest x-ray and fluoroscopic examination should be done and bronchograms and bronchoscopic examinations may be useful to rule out other serious pulmonary conditions. When the sputum is purulent, sputum culture should be performed with sensitivity studies to aid in appropriate antibiotic therapy. Pulmonary function studies, particularly the timed vital capacity, are helpful in determining degree of disability.

On physical examination important clues to the presence of emphysema may often be found. The use of accessory muscles of respiration with the chest held in inspiratory position, increased AP diameter of the chest, distant breath sounds (occasionally with wheezing), and hyperresonant percussion note, are all classical findings. In severe cases there may be cyanosis or plethora, clubbing of the fingers and signs of right heart failure.

Treatment

The treatment of chronic emphysematous bronchitis must be based on careful individual evaluation of each patient. Since this disease may exist in all stages, from the individual who merely has the chronic "cigarette cough" and gets a little short of breath climbing one or two flights of stairs, to the individual dying with almost total ventilatory insufficiency, pulmonary acidosis and right heart failure, it is obvious that one plan of treatment will not suit every patient with the diagnosis of chronic emphysematous bronchitis. However, the practical aims of treatment in all categories are (1) to remove and relieve all possible sources of bronchial irritation, (2) to improve the mechanics of breathing and (3) to reverse, stop or slow the progress of the disease whenever possible.

The basic tools of treatment may be summarized as follows: (1) Control of air pollution. The patient should be removed from the source of polluted air, whether this be industrial dust or fumes or other irritants or complete and total interruption of the smoking habit. Some physicians, particularly those who smoke themselves, will be more lenient and advise the patient to switch to a filtered smoke but I feel that this compromise leaves much to be desired and is a poor substitute for no smoking.

Medication

(2) Expectorant medication. The amount of expectorant drugs included in ordinary proprietary cough mixtures is totally inadequate. Saturated solution of potassium iodide ten drops four times daily at the onset with increase of dose up to twenty drops four times daily if tolerated is an excellent and inexpensive preparation. In patients who do not tolerate potassium iodide, ammonium chloride in 1 gm. enteric tablets four to six times daily may be substituted. These medications should be continued for a prolonged period of time and in most instances indefinitely.

(3) Mucolytic preparations. During acute exacerbations of this disease associated with quantities of inspissated tenacious bronchial secretions, mucolytic preparations given by aerosol will prove useful. The value of ordinary water, either as steam in a croup tent or as a cold vapor per nebulizer must not be underestimated. Turgemist® and Alevaire® are two commercial mucolytic agents which have found a firm place in our armamentarium. A new product N-acetyl-L cysteine has had excellent

reports in the clinical testing phase and probably will soon be released by Mead Johnson & Company.

(4) Antibiotics. Chronic emphysematous bronchitis is almost always associated with bouts of purulent sputum and frequently with fever and other manifestations of respiratory infection. Whenever infection complicates the picture appropriate antibiotics should be used promptly, vigorously and for a sufficient period of time to do some good. As I mentioned before, sputum cultures and sensitivity studies may aid in directing suitable antibiotic therapy. When it is not practicable to obtain a sputum culture and a diagnosis has been established on other grounds, therapy should be initiated with antibiotics notwithstanding. Tetracycline with nystatin, Declostatin®, and Terramycin® are particularly useful. Chloramphenicol is a very effective drug for treating mixed respiratory infection but due to its bone marrow depressing effects should not be used empirically unless other drugs have been tried, have failed to accomplish the desired control of infection and the patient's condition is serious.

Broncho-dilators

(5) Broncho-dilators. Where the element of bronchospasm is apparent, individuals with severe dyspnea associated with wheezing and with the physical findings of high pitched musical expiratory rhonchi, broncho-dilator medications are useful. Orally Elixophyllin® or ephedrine may be used. For nebulization I prefer a 1:200 solution of Isuprel® administered three or four times daily as needed either by hand nebulizer or by one of the currently available compressed gas type cartridges. Aminophylline rectal suppositories are fairly good broncho-dilators and in patients ill enough to require hospital therapy intravenous aminophylline is frequently very helpful. Intravenous aminophylline may be given either by slow injection of 3¾ grains of aminophylline in 10 ml. solution or by continuous intravenous drip of 500 to 1000 ml's of 5% dextrose in water containing 15 grains of aminophylline.

(6) Cough Suppressants. While cough suppressants are extremely valuable in treating the emphysematous bronchitis victim in the early stages, their use should be governed by extreme caution in the patient with advanced disease lest depression of respiration and retention of secretions occur, precipitating a critical episode. In spite of the efforts of the pharmaceutical industry to produce a better product, codeine still remains the therapeutic agent by which the efficacy of all others is measured. Codeine is probably less habit forming and as efficacious as dihydrocodeinone. The principal of treatment with cough suppressants should be to relieve the harassing, fatiguing and irritating cough but to stop short of overly depressing the cough reflex. The dose should be adjusted to suit the individual's need. A trial of non-narcotic cough suppressant such as Novrad® may be justified when there is fear that addiction may be a problem.

Positive Pressure Therapy

(7) Intermittent Positive Pressure Therapy (IPPB). Although there has been considerable debate on the subject, I am convinced that the use of IPPB in the individual with moderate to severe emphysematous bronchitis when accompanied by the administration of a bronchodilator and mucolytic aerosol can be of definite help. I have had the experience of administering IPPB to the individuals in apparent extremis with acute respiratory insufficiency associated with chronic emphysematous bronchitis and have seen them recover to the point of returning to a fairly useful life for several years thereafter. The frequency of use of the IPPB therapy varies from once or twice weekly to several times daily. Obviously, the more frequent usage is reserved for patients in the hospital or who have obtained equipment to administer treatment to themselves in their own homes.

Corticosteroids

(8) Corticosteroids. Corticosteroids such as prednisoline, prednisone or triamcinolone frequently produce dramatic results in the course of the patients with severe symptoms, but the danger of prolonged usage of these drugs is such that they should be reserved for those individuals who fail to respond to other therapy described. Ordinarily small doses will suffice. The equivalent of 5 milligrams of prednisoline four times a day at the onset gradually reduced

to a maintenance dose of 5 to 10 milligrams daily will usually suffice.

Summary

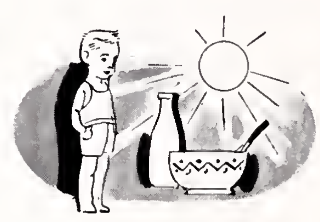
The following chart correlates the various modalities of treatment with the stage and severity of the disease.

In conclusion I want to emphasize the importance of individualization of treatment, the removal from the patient of bronchial irritants in general and smoking in particular, the judicious use of expectorant medication and control of infection.

TREATMENT OUTLINE
CHRONIC EMPHYSEMATOUS BRONCHITIS

Disease Classification	Treatment Modality							
	Air Pollution Control	Expectorants	Mucolytics	Antibiotics	Broncho-dilators	Cough Suppressants	Mechanical Aids-IPPB	Steroids-Others
Mild	xxxx*	xxxx	x	x				
Moderate	xxxx	xxxx	xx	xx	x	xx		
Severe	xxxx	xxxx	xxx	xxx	xx	xx	xx	x
Severe Complicated**	xxxx	xxxx	xxx	xxx	xxx	xx	xxx	xx

*Number of x's show relative frequency of use
**Right heart failure, respiratory acidosis, polycythemia



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EDITORIALS

She Ain't Dead Yet

MUCH has been written and spoken in recent years concerning the present status, or plight, and the immediate future prospects of the University of Louisville School of Medicine—not all of it has been complimentary or encouraging. Nearly half the physicians in Kentucky claim this institution as their Alma Mater and are vitally interested in its future. In recent years they have come more faithfully than ever to its aid spiritually and financially. The recent accelerated activity of the Alumni Association has produced a substantial increase in contributions from alumni both through the Association and through the American Medical Association's AMA-ERF program. The annual seminars provided for graduates have been better attended and with greater interest than ever before.

The necessary increase in tuition has, of course, handicapped the school somewhat in its quest for excellent students. The Alumni Association and other organizations have provided a modest number of scholarships designed to offset this difficulty. We thereby have held some promising students who otherwise would have enrolled in other schools.

The division of responsibility for educating Kentucky students has allowed the University of Louisville to accept a greater number of applicants from out of the state. The Medical School therefore tends to revert to its original cosmopolitan character by attracting excellent students from outside—this is good. A great number of the physicians in Kentucky came here from other states in order to study medicine and remained here to practice. In many instances they became leaders in their respective fields. These men are well dispersed over the State. There is no reason to believe that this trend will not continue.

The dedication this year of the new Medical and Dental Research Unit has added tremendously to the potential for the University. This is a magnificent building with ample space for research, teaching, and some clinical facilities. It provides for much better teaching during the preclinical years. The crowded conditions at the main building have been considerably relieved.

The next major step in development is a plan for erection of a new building for instruction adjacent to or in connection with the research building to replace entirely the antiquated structure at First and Chestnut—it seems certain that this will be accomplished within the next few years. There are many physicians who are sentimentally attached to this structure and regret to see it replaced. It is however an essential step in the progress of the University if it is to keep in line with modern trends in medical education. The change should be effected with the greatest possible speed.

The year in which we elect the governor is an excellent time to formulate plans. In the last three preceding campaigns the University of Louisville has had the assurance from every major candidate that he would do everything possible to improve the physical facilities and continue state financial support to the University of Louisville School of Medicine. The

candidates in this year's race have all been more than usually positive in their favorable position on this particular subject.

The progress of the school—or lack of it—during the past 15 years has been the subject of lively discussion. It is appropriate to recount some of the accomplishments of this period.

In 1949 we had one or two full-time members of the medical school staff who were the heads of a clinical department. There are now eight. Full-time faculty members altogether have doubled in number during the same time. The school's operating budget has risen during this period from $542,000 to $3,179,000 annually. Outside support for research and training has grown from $169,000 to $2,500,000.

These indications of progress are not accepted by everyone as a true index of proper growth of the school. They are, however, standards by which modern medical schools are being measured and whether we wish it or not we cannot revert to the standards of two decades ago and still survive.

The enlargement of the medical center by the construction of the new Cancer Research and Treatment Unit and The Rehabilitation Unit are essential steps in our progress. There is now developing a plan for the establishment of a new hospital in the medical center primarily for the use of faculty members in their private clinical work. It is a matter of some difference of opinion as to whether these teachers would do better to use the facilities of privately operated hospitals and thereby work more closely with men in private practice. A more intimate and cordial relationship between the two groups is needed. There is however a growing sentiment to provide a hospital which faculty men may use and control. If that is the price that we must pay to obtain and hold men of stature as teachers in the clinical years; if that provision is necessary for the growth and progress of the school, then it would be well for us to cooperate toward that end.

In the last five years there has been a gradual increase in the number of applicants at the University of Louisville School of Medicine for entrance into the Freshman year and we are assured by the Admissions Committee that these applicants show generally somewhat better educational preparation than they did five years ago. Our classes have remained at the same level numerically during this period and we are informed that the scholastic standing for the present freshman class is better than it has been for perhaps a decade. These are most encouraging assurances.

Considerable publicity has been given to the departure of some department heads and of some very excellent teachers in the several fields. Less publicity has been given to the replacement of these men, sometimes by teachers of greater promise than those who were lost. This type of loss and replacement is an increasing problem in all of the medical schools in the United States. It is perhaps no greater problem here than in the majority of medical schools across the country and contrary to the expressed fears of many we seem to have been about as successful in obtaining replacements as have most of the other institutions.

These evidences of growth and strength apply particularly to a period of 15 years under the Deanship of Dr. J. Murray Kinsman. It has been a difficult period, beset with many discouragements and criticisms, which have often seemed unfair, but which generally have arisen from lack of proper information as to what is actually going on at school. With the coming year Dr. Kinsman will assume the position of Vice-President of the University and he will be concerned with the wider aspects of growth and development for the Medical School. He is widely known throughout the state. He has a broad base of experience both in private practice and in medical teaching and administration. He has attained considerable stature nationally in both the field of clinical medicine and medical education. He should be able to accomplish a particularly fruitful mission for the school in his new role.

Dr. Donn L. Smith, the new dean effective July 1st of this year, comes to us with unusual promise. At the age of 47 he holds both a Doctor of Philosophy and a Medical Degree from the University of Colorado in which institution he has spent most of his career in education. He now holds the position there of Associate Dean of the Medical School and Assistant to the Vice-President of the University for medical affairs. He presents an enviable record of academic accomplishments. Those of our faculty who have made his acquaintance are most enthusiastic about him and feel that the committee for the selection of a dean has at last made an excellent choice.

The stately but ancient structure at First and

Chestnut, Vintage of 1893, is scheduled for desertion or destruction. To its thousands of alumni, however, it will stand forever as sort of a sacred symbol. It is what remains of eight medical schools which flourished—or at least functioned—in that era. At the peak of their activity as many as 489 medical graduates were numbered in one year. Louisville, as the leading medical center of the South, provided more physicians for the South and Southwest than any other city and these included many of the nation's medical leaders. Until after World War I the Medical School was most that counted of the University.

It has had perhaps more downs than ups, more lean than fat years. There were periods when it seemed to hang on by the skin of its teeth and times when it looked like a plucked chicken in a cold wind. But it has survived and it stands now at the threshold of a greater destiny. It will be making its ever increasing contribution to medical progress long after the youngest of its present graduates has gone to his reward.

Sam A. Overstreet, M.D.

Civic Participation

"WE believe that service to humanity is the best work of life."

This motto is recited daily in free countries across the world. It is a part of the Creed of the Junior Chamber of Commerce.

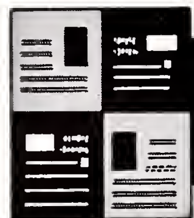
The Kentucky State Medical Association has noted with pride that one of its members, Fred Rainey, M.D., Elizabethtown, has been elected President of the Kentucky Junior Chamber of Commerce for the 1963-64 Jaycee year.

The medical profession has long maintained a high regard for the Jaycees. Their actions and the very nature of their organization has gained the admiration of many other outstanding groups. Although their numerous projects make all of our communities a better place in which to live, their main purpose for existance and their greatest asset, is the high quality of leadership cultivated within their own membership.

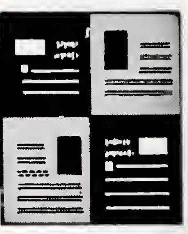
We are now living in an era that requires more and more members of our profession to assume a leadership role in all phases of our daily lives. Doctor Rainey, a public spirited and dedicated young physician, has demonstrated his willingness not o nly to take an interest in the affairs of his community, but to devote the necessary time to serving in this interest.

In the past Doctor Rainey's actions have displayed enthusiasm for his profession, for his church, and for the entire betterment of his community. Last year he served the KSMA as a member of the General Practice Committee and a Congressional Legislative Keyman. He was reappointed as a Keyman this year, participated on the KSMA Senior Day Program, and served for a short term as Secretary to KEMPAC.

Doctor Rainey brings honor to both himself and this association as he steps into the highest position of leadership afforded by our state's "Young Men of Action," the Jaycees.



SPECIAL ARTICLES



Teaching Community Medicine

JESSE W. TAPP, JR., M.D., M.P.H.†

Lexington, Ky.

IS "general practice" being taught at the University of Kentucky College of Medicine? What training are future health officers receiving? How many hours of occupational medicine are there in the curriculum? Is narrow specialization being encouraged? These questions are being asked about this new medical school that is expected to provide more physicians for all the varied medical needs of Kentuckians.

No simple answer to these questions can be given for the school as a whole, nor can a single department speak to all of them. However, the department of Community Medicine[1] is developing a teaching program which deals with some of the practical problems of medical and public health practice in the community.

Each medical student, during his senior year assignment in Community Medicine, is taken away from the "Ivory Tower" of the University Hospital for five weeks. He is placed in a typical Kentucky community with the assignment of studying patients in a physician's office using the same rigorous standards he used in the University Hospital. He is required to study the operation of the local health department, and the opportunity is afforded to accompany the health officer, the public health nurse, and the sanitarian as they go about their respective duties. He is sent to such places as the court house and the welfare agencies to learn about the social, economic, and political life of the county, and challenged to explain how these factors are interrelated with the health problems he has studied. He spends enough time in the local industrial plant or coal mine to understand the health problems of the workers and how their safety is the responsibility of the physician.

Each week the student is visited by the faculty supervisor from the Department of Community Medicine. In the community, a local cooperating physician is in charge of the student's daily activities. The visiting faculty member, the local physician, and the student meet together to discuss the clinical experiences which the student has had in the doctor's office and in the homes of families he has studied. These teaching sessions are conducted in the same disciplined format as are conferences at the University Hospital.

The student is expected to perform the routine laboratory procedures usually indicated for a thorough understanding of his patients' medical problems. Special equipment, such as an electrocardiograph, may be loaned to him, if necessary. Specimens are sent to the university pathology laboratory for special studies as indicated. Occasionally a specialist consultant may be brought to the bedside, if desired by the local attending physician, in order to assure that the student learns the best possible way to evaluate a patient in his own community setting. In addition, the student reports on his attendance at the meetings of the local medical society, board of health, fiscal court, civic clubs, and other groups that help him understand the total community health picture.

In certain situations, the student carries out epidemiologic studies of his own design, or in relation to special needs of the local physicians or health department in cooperation with the Department of Community Medicine. These may include such basic problems as the prevalence of tuberculin and histoplasmin sensitivity or intestinal parasitism. One student instituted a cervical smear cancer detection program in the office of a general practitioner.

Other members of the Department of Community Medicine have special responsibilities for advising the students in their work. The public health nurse-epidemiologist is available to assist in studies and in work with the local public health nurses. The social anthropologist, who has a special interest in medical and public health problems, visits each student to assist in developing his family studies.

A comprehensive outline for a local health study, originally published by the World Health Organization[2], is followed by the student in preparing his report on the status of his community. During the sixth week of the program, he has the opportunity to present his work to his fellow students and the Depart-

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†Coordinator of Community Medicine Clerkship Program, University of Kentucky College of Medicine, Lexington, Kentucky.

ment of Community Medicine during a series of seminars in which the students are the principal contributors.*

Each group of students comes together under the leadership of men of long experience in the fields of public health, medical practice, medical economics, community organization and education, occupational and legal medicine, and other areas of special concern, to discuss their own findings with the experts. Each student is assigned to a different type of community so that among the group a wide variety of situations is represented. One student may have studied a county with only one physician and perhaps not even a part-time health officer. A second student may have worked in an active health department in a larger community. A third student has experience with the details of a group practice of medicine, or perhaps the operation of an industrial medicine program, in addition to his knowledge of the general community.

In this way, each student has his own area of particular experience to share with the entire group. One of the seminars is devoted to discussing the opportunities which have been observed in the various physicians' practices for continuing medical education, and how these can be utilized to keep up with the accelerating changes in medicine.

Financial Support

The Community Medicine Clerkship, as it is called, is a new program in medical education. Because it is experimental, it is being generously supported by the Commonwealth Fund of New York for a three year period. This financial support is making it possible to reimburse the students for their expenses in the field and provide the intensive faculty supervision.

The clerkship is not the first contact between the students and the Department. In the sophomore year, a twenty four week course in epidemiology introduces the student to the principles and methodology he will be called upon to use in the field. In addition to giving the historical perspective necessary to appreciate the current importance of public health and preventive medicine, the student is trained in critical analysis of the medical literature in weekly seminars in which he is a major participant.

It is important to differentiate the clerkship concept from the preceptorship programs which are well known at a number of medical schools. Foremost is to emphasize that the student is assigned to study the entire community rather than the practice of a particular preceptor. This means that although the student is assigned to a particular physician for daily guidance, it makes no difference whether he be generalist, specialist, or health officer; the student is still responsible for learning about all aspects of medicine in the area, and much that is not primarily medical, as well.

In the first senior class there are four students in each six week rotation, but when the school reaches full enrollment of 75 students per class, there will be nine or ten students assigned to communities in in each rotation.

In a preceptorship, it is not customary for the full-time faculty to visit the field frequently or participate in the detailed field teaching, while here the Department of Community Medicine is being extended directly into the community under study. The very fact that this program is the specific activity of a single academic department with particular teaching responsibilities differentiates it from a preceptorship, which is often under the aegis of the dean or a committee with very general aims.

Comparisons

This clerkship also differs from the public health summer service programs which have been carried on in Kentucky for a number of years, or for that matter, from the clinical clerk programs of hospitals all across the country. These opportunities, although inherently educational, are primarily designed to provide the ancillary service which a third or fourth year medical student is competent to supply. The dangers are ever present that the student may overstep the boundary between assistance and actually practicing medicine, or he may be used only to perform menial tasks with little or no instruction.

While the student of community medicine does have time to do a few school physical exams and routine laboratory tests, he is occupied to a greater extent in developing his competence to evaluate the needs of the total patient and his community. He is expected to look beyond the immediate situation at the needs for rehabilitation, improvement of home care, development of chronic care facilities, etc.

This program has been in pilot operation for two years with students "borrowed" from other schools specifically for the purpose of testing the various aspects of the teaching project. Eight students representing the medical schools of four universities were assigned to communities in twelve counties for a variety of experiences. The pattern of these trial clerkships was as described above, with variations and improvements introduced as indicated. The effect on the students involved was felt to be very favorable for the concerns of medical education in Kentucky. Without exception, the students were grateful for having an opportunity, while still in medical school, to get a critical perspective on medicine in the real world. They found this opportunity very helpful in shaping their own career plans. Several have indicated real interest in entering practice in a small community.

Physicians Pleased

The physicians who served as mentors in the various selected communities were pleased with the arrangement for it gave them a vital participating role in medical education in addition to a stimulating contact with the University Medical Center. The studies which were prepared proved helpful to the physicians and health departments. New laboratory techniques introduced by the students in some instances were retained as regular procedures. More students have been requested by these physicians, and there remains

little doubt that the trial clerkships were successful for students, local physicians, and faculty.

In the foregoing discussion, no mention has been made of a department of preventive medicine, public health, or general practice. We believe that no department of a medical school should proselytize for a particular medical specialty; however, it is our firm conviction that each student should learn the skills necessary for studying and understanding the area which he serves. He should learn the relationships between all the areas of medical knowledge and each individual patient and community health problem. Then, regardless of what type of practice he chooses, the student is equipped to serve and understand the total patient and his needs, as well as the family and community in which the patient lives. The Department of Community Medicine has part of the responsibility for emphasizing the importance of family medicine in interaction with all the ecological factors which determine the health of the aggregate community.

In summary, the senior medical student teaching program of the Department of Community Medicine, University of Kentucky College of Medicine, has been described. This program consists of an intensive educational exposure for all senior medical students to selected communities where they learn firsthand the subject matter traditionally taught in courses of public health or preventive medicine. In addition, all aspects of medicine and society are exposed to the students' scrutiny including the general and special practice of medicine.

REFERENCES

1. Deuschle, K. W., and Fulmer, H. S., Community Medicine: A "New" Department at the University of Kentucky College of Medicine. J. Med. Educ., 35:434-45, May 1962.
2. W.H.O. technical bulletin #194, 1960.

You Will Not Want To Miss These Features of the KSMA Annual Meeting

Lexington — September 23-26

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Fourteen Specialty Groups

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Research in the Service of Medicine

ORGANIZATION SECTION

Outstanding Speakers To Address KSMA Annual Meeting

The 1963 Kentucky State Medical Association Annual Meeting September 24-26 at Lexington will be addressed by several noted specialists in the field of medicine, according to a preview of the program recently released by David M. Cox, M.D., KSMA president, and Edmund D. Pellegrino, M.D., Lexington, program chairman.

The introduction of color television for the purpose of presenting case studies and other pertinent information, will be another highlight of this year's program. The closed-circuit programs will originate from the University of Kentucky Medical Center Hospital, and will be used in conjunction with various panel discussions, as yet not completely scheduled.

Fourteen specialty groups will participate in the session.

Panel discussions will be presented on the following subjects: "Dermatologic Problems of General Medicine", "Diagnosis and Treatment of Common Skin Disorders", "Etiologic and Therapeutic Aspects in Pyelonephritis", "Obesity", "Tumors of the Head and Neck", "Environmental Factors in Lung Cancer", and "Hypertension".

Biographical information has been provided by Doctor Cox on four of the featured speakers for the session. Information on all speakers will appear in subsequent issues of the Journal.

Richard Brasfield, M.D., surgeon from New York City, will take part in a general session panel discussion Thursday morning on "Tumors of the Head and Neck", and will address his host specialty group on a subject to be announced at a later date.

Doctor Brasfield is clinical instructor of surgery at Cornell University Medical College and assistant clinician at the Sloan Kettering Institute. He is a 1944 graduate of the Vanderbilt University Medical School in Nashville, and is at present associate staff president of New York Memorial Hospital.

Doctor Brasfield

Doctor Davis

Doctor Perry

Doctor Wise

David M. Davis, M.D., will take part in the general session Tuesday afternoon in a discussion of "Etiologic and Therapeutic Aspects in Pyelonephritis", and will address his host group, the Kentucky Urological Society, on Tuesday morning. The topic of his paper has not yet been announced.

Doctor Davis attended Princeton University and received his M.D. from Johns Hopkins University in 1911. Starting as an assistant in pathology at Johns Hopkins, he became pathologist and director of research of the Brady Urological Institute. Doctor Davis moved to Philadelphia in 1935, where he became professor of urology in Jefferson Medical College, a position he held until assuming Emeritus status in 1951. He is currently a visiting lecturer in urology at the Graduate School of Medicine, University of Pennsylvania.

Harold O. Perry, M.D., dermatologist from Mayo Clinic in Rochester, Minn., will be the guest of the Kentucky Academy of General Practice and will participate in the general session of the KSMA Annual Meeting on Tuesday morning in the panel discussion of "Dermatologic Problems of General Medicine". He will present a paper to the KAGP on Wednesday afternoon. The title of his address will be announced.

Doctor Perry, a graduate of the University of Minnesota Medical School in 1946, is assistant professor of Dermatology at the Mayo Foundation, University of Minnesota Graduate School.

Robert I. Wise, Ph.D., M.D., Philadelphia, guest of the Kentucky Chapter, American College of Physicians, will present the Internist's aspects during the general session panel discussion, "Etiologic and Therapeutic Aspects in Pyelonephritis", and will further address his host specialty group at their meeting on Wednesday afternoon.

Doctor Wise currently holds the appointment of Magee professor and head of the department of medicine at the Jefferson Medical College in Philadelphia. In addition, he has taught in the department of medicine at the University of Minnesota and at the Universities of Illinois and Texas.

Council on Scientific Assembly Releases First Draft of Program for 1963 Annual Meeting September 24-26

Closed-circuit color television presentations will highlight the Scientific program of the KSMA Annual Meeting in Lexington September 24, 25 and 26. A preliminary draft of the program for the Annual meeting was recently released by David M. Cox, M.D., Louisville, KSMA president and chairman of the Council on Scientific Assembly and Arrangements, and Edmund D. Pellegrino, M.D., chairman of the Scientific Program Committee.

The television showings will originate from the U.K. Medical Center Hospital and will be interspersed throughout the meeting. Plans for scheduling the TV clinics will be completed this month.

The following draft of this program is subject to changes:

Tuesday, September 24

Morning Session

8:45 **Opening Ceremonies**

9:00 TV Clinic—"**Diagnosis and Treatment of Common Skin Disorders**"
A. B. Loveman, M.D., Louisville, Moderator
Harold Perry, M.D., Rochester, Minn.
Carey C. Barrett, M.D., Lexington
Ullin W. Leavell, Jr., M.D., Lexington
William E. McDaniel, M.D., Lexington

10:00 **Visit Exhibits**

10:30 Panel Discussion—"**Dermatologic Problems of General Medicine**"
A. B. Loveman, M.D., Louisville, Moderator
Dermatologic Aspects:
Harold Perry, M.D., Rochester, Minn.
Winston U. Rutledge, M.D., Louisville
Pediatric Aspects:
Walter T. Hughes, M.D., Louisville
Internist's Aspects:
Lloyd D. Mayer, M.D., Lexington
General Practitioner's Aspects:
Arnold C. Williams, M.D., Lexington

Specialty Groups Meeting During Morning Session

Kentucky Obstetrical and Gynecologic Society
Kentucky Orthopaedic Society
Kentucky Urological Society

12:00 **Luncheon**

Afternoon Session

2:00 Panel Discussion—"**Etiologic and Therapeutic Aspects in Pyelonephritis**"
Robert Lich, Jr., M.D., Louisville, Moderator
Obstetrical Aspects: H. H. Ware, M.D., Richmond, Va.
Pediatric Aspects: Katharine Dodd, M.D., Atlanta, Ga.
Internist's Aspects: Robert I. Wise, M.D., Philadelphia, Pa.
Urologic Aspects: David M. Davis, Haverford, Pa.

3:30 **Visit Exhibits**

4:00 H. H. Young, M.D., Rochester, Minn.
Subject: "**Plea for Conservatism in the Treatment of Fractures**"

4:20 Charles D. Carter, D.M.D., Bowling Green, Ky.
Subject: To be announced

Specialty Groups Meeting During Afternoon Session

Kentucky Psychiatric Association

Wednesday, September 25

Morning Session

9:00 Panel Discussion—"**Obesity**"
William W. Winternitz, M.D., Lexington, Moderator
General Practitioner's Aspects: William VonderHaar, M.D., Louisville
Psychiatric View: Bernard Holland, M.D., Atlanta, Ga.
Pediatric Aspects: Kenneth P. Crawford, M.D., Louisville
Genetic Aspects: C. Charlton Mabry, M.D., Lexington
Orthopaedic Aspects: H. H. Young, M.D., Rochester, Minn.

10:30 **Visit Exhibits**

11:00 **Presentation of the award for the best scientific exhibit and awards to the two medical schools**
President's Address

11:50 **President's Luncheon**

Specialty Groups Meeting During Afternoon Session

Kentucky Society of Anesthesiologists
Kentucky Chapter, American Academy of General Practice
Kentucky Chapter, American Academy of Pediatrics
Kentucky Chapter, American College of Physicians
Kentucky Chapter, American College of Surgeons
Kentucky Radiological Society

Thursday, September 26

Morning Session

9:00 Panel Discussion—"**Tumors of the Head and Neck**"
Ben Rush, M.D., Lexington, Moderator
EEN&T Aspects: Charles Perera, M.D., New York City
Surgical Aspects: Richard Brasfield, M.D., New York City

X-Ray Therapy Aspects: Robert H. Greenlaw, M.D., Lexington
Internist's Aspects: Giovanni Raccuglia, M.D., Ann Arbor, Mich.

10:00 **Visit Exhibits**

11:00 Panel Discussion—"**Environmental Factors in Lung Cancer**"
Hugh S. Fulmer, M.D., Lexington, Moderator
Chest Physician's View: Paul W. Sanger, M.D., Charlotte, N.Car.
Pathological Aspect: Averill Liebow, M.D., New Haven, Conn.
Statisticians' Aspect: Alan Ross, Lexington

12:00 **Lunch**

Afternoon Session

2:00 Panel Discussion—"**Hypertension**"
Thornton Scott, M.D., Lexington, Moderator
General Practitioner's Aspects: Robert M. Sirkle, M.D., Lexington
Surgical Aspects: Frank C. Spencer, M.D., Lexington
Radiological Aspects: John Hodgson, M.D., Rochester, Minn.
Anesthesiological Aspects: J. Jay Jacoby, M.D., Milwaukee, Wis.

Specialty Groups Meeting During Afternoon Session

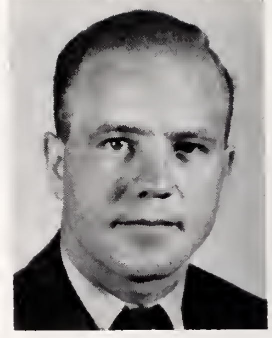
Kentucky Chapter, American College of Chest Physicians
Kentucky EEN&T Society
Kentucky Society of Pathologists
Kentucky Association of Public Health Physicians

Ky. C. of C. Campaigns Against King-Anderson Bill

A slide presentation, emphasizing the evils of the King-Anderson proposal of compulsory medical care for the aged, is being shown to business and civic leaders in all counties in the state by the Kentucky Chamber of Commerce.

The program points out that private voluntary methods of health and medical care through insurance have increased in recent years, and that those who need financial assistance are now able to receive it through the Kerr-Mills program. The King-Anderson Bill, the Chamber stresses, would provide a federal program of compulsory health care financed by increased Social Security taxes and additional expenditure of regular revenue.

The Chamber of Commerce hopes, by showing these slides to a large portion of the state's population, to promote a greater understanding of the pitfalls of compulsory medical care through the Social Security program. County medical societies wishing further information about the presentation should contact the Kentucky Chamber of Commerce at 670 South Third St., Louisville 2, Ky.



Doctor Kinsman   Doctor Smith

U. of L. Medical School Names Doctor Smith New Dean

Donn L. Smith, M.D., Denver, Colo., will assume the post of Dean of the University of Louisville School of Medicine on July 1, according to a recent announcement by the U. of L. Board of Trustees. Doctor Smith will succeed J. Murray Kinsman, M.D., who will become a vice-president of the University.

Doctor Smith, 47, is at present associate dean at the University of Colorado Medical School in Denver, and assistant to the vice-president for medical affairs. Doctor Kinsman, Dean of the School of Medicine since 1949, will join William J. McGlothlin, also a vice-president, in making a survey of medical needs and recommendations for future changes in the medical school.

Concerning his appointment, Doctor Smith said, "I am delighted to become a member of the faculty of the University of Louisville, and sincerely hope that I can do the type of job that the University and the community deserve." The announcement climaxed a search of nearly a year by a committee headed by Rudolph J. Noer, M.D., professor and chairman of the department of surgery at the University.

Doctor Smith received his M.D. degree from the University of Colorado school of Medicine in 1958, after acquiring a degree of Ph.D. in physiology from Colorado in 1948. His bachelor's degree in zoology was earned at the University of Denver. He is a former recipient of four major fellowships in science and medicine, and has been active in research and medical scholarship.

A veteran of World War II, Doctor Smith is married and is the father of two children.

Doctor Kinsman, who will, as a vice-president, work on long-range plans for improving the university's medical education program, came to Louisville in 1925 as a resident at General Hospital. He is a native of Nova Scotia, Canada, and received his medical degree in 1922 from McGill University.

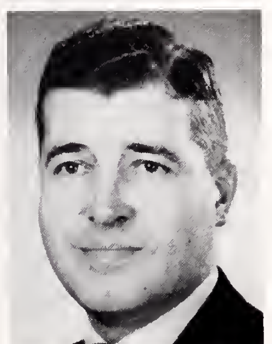
New KSMA Members Announced

The following physicians are new members of the Kentucky State Medical Association: R. G. Aug, M.D., F. B. Wells, M.D., Borys Surawicz, M.D., and J. E. Warren, M.D., all of Lexington, and Phil Harbrecht, M.D., Louisville.

Photographed at the recent Lexington Meeting of the Kentucky Surgical Society are its officers. From left to right are C. Melvin Bernard, M.D., immediate past president of the Society, Delmas M. Clardy, M.D., new president, Alvin B. Ortner, M.D., vice-president, and Blaine Lewis, M.D., who begins the second year of his three-year term as secretary.

Doctor Seeley Named To Head KAGP

Ellsworth C. Seeley, M.D., London, Ky., was named president-elect of the Kentucky Chapter of the American Academy of General Practice at the annual meeting May 7-10 held at the Kentucky Hotel in Louisville. He will take office in 1964, succeeding J. Sankey Williams, M.D., Nicholasville.



The 12th annual scientific assembly of the KAGP was addressed by eight outstanding specialists in the field of medicine during the three-day session.

Other officers elected by the KAGP were vice-presidents Joseph R. Miller, M.D., Benton; John Rulander, M.D., Louisville; Arnold C. Williams, M.D., Lexington, and Paul Sides, M.D., Lancaster. Robert M. Sirkle, M.D., Lexington, was re-elected secretary.

Named as delegates to the American Academy of General Practice were Julian B. Cole, M.D., Henderson; and Edgar B. Morgan, M.D., Louisville. Re-elected speaker of the congress of delegates was Patrick Murphy, M.D., Lebanon Junction. James Davis, M.D., Louisville, was named vice-speaker.

Doctor Williams, outgoing president of the KAGP, was elected "Citizen Doctor of the Year." He has been active in opposing the King-Anderson Bill. In a separate action, an award for the outstanding scientific paper of the year was presented to Carroll Witten, M.D., Louisville. His paper on "Nose Bleed" appeared in the December issue of the General Magazine.

The Tennessee Valley Medical Assembly will meet at Read House in Chattanooga, Tennessee, on September 30 and October 1, 1963.

Ky. Surgical Society Elects Doctor Clardy President

Delmas M. Clardy, M.D., Hopkinsville, was elected president of the Kentucky Surgical Society at the May 17-18 meeting held in Lexington. He succeeds C. Melvin Bernard, M.D., Louisville, to the presidency. Doctor Clardy, KSMA treasurer, has held a number of committee chairmanships within the KSMA, and is now chairman of the Public Health Committee.

Alvin Ortner, M.D., Louisville, was named vice-president. Blaine Lewis, M.D., Louisville, begins the second year of a three-year term as secretary. J. Duffy Hancock, M.D., Louisville, became chairman of the Council, replacing Branham B. Baughman, M.D., Frankfort, who has completed his term on the council.

Bernard Zimmerman, M.D., professor and chairman of the department of surgery at the West Virginia University School of Medicine, Morgantown, was the guest speaker at the two-day session, held in association with the department of surgery at the University of Kentucky.

New members elected to the Society were: Charles J. Bisig, M.D., John L. Creech, M.D., Harvey C. Hardegree, M.D., Herbert T. Ransdell, Jr., M.D., and Frederick C. Reiss, M.D., all of Louisville; Rene Menguy, M.D., and W. Porter Mayo, Jr., M.D., Lexington; and Thomas T. Myre, M.D., Paducah.

Approximately 100 of the limited membership of 125 attended the session at Lexington. In 1964 the Society will meet on May 15-16 in Nashville in association with the department of surgery at Vanderbilt University.

Society Executives To Meet

The Medical Society Executive Association is holding a three-day intensive workshop for new Medical Society executives at Atlantic City just before the AMA Annual Meeting begins June 16.

J. P. Sanford, KSMA Executive Secretary, will preside during one afternoon session of the seminar, which is limited to 30 registrants.

New officers of the Kentucky State Association of Medical Assistants are shown following elections at the May 19 session of the first annual convention in Louisville. From left to right are Lillian Smith, vice-president; Dorothy Downs, president-elect; Mary Crump, 1963 president; Alice Bach, corresponding secretary; and Phoebe Faust, who was re-elected treasurer. Shown in the background is Bettye Fisher, Evansville, Ind., immediate past president of the American Association of Medical Assistants, who assisted at the installation of the officers. Recording secretary Pat Medley was unable to be present for the photograph.

Medical Assistants Meet In Louisville May 18-19

The Kentucky State Association of Medical Assistants held its first annual convention in Louisville at the Kentucky Hotel May 18-19. During the two-day session Mary Crump, Frankfort, was installed as president for the coming year, succeeding Louise Hawkins, Louisville.

Other officers elected during the meeting were: Dorothy Downs, Louisville, president-elect; Lillian Smith, Frankfort, vice-president; Pat Medley, Louisville, recording secretary; and Alice Bach, Frankfort, corresponding secretary. Phoebe Faust, Louisville, was re-elected treasurer. Directors of the Association are Rose Ultechi, Frankfort, and Ernestine Gates, Louisville.

David M. Cox, M.D., president of the Kentucky State Medical Association, addressed the State Luncheon on Sunday, May 19. A variety of speakers from the medical profession and allied fields addressed the members during both sessions.

Hospital Honors Twelve

St. Anthony Hospital in Louisville recently honored 11 physicians and a dental surgeon with gifts and citations in recognition of their total 641 years of service on the staff of the hospital. A. David Willmoth, M.D., was honored as the oldest doctor—he joined the staff of St. Anthony's in 1896. William H. Allen, M.D., and Frank P. Strickler, M.D., were the youngest men present. Both came to St. Anthony's in 1915.

Others recognized were John A. Brennan, M.D.; George B. Breidenthal, M.D.; Emmet F. Horine, M.D.; J. Allen Kirk, M.D.; Elmer C. Hume, D.D.S.; Garland L. Dyer, M.D.; Walter I. Hume, Sr., M.D.; Lamar W. Neblett, M.D.; and W. Stewart Carter, M.D.

Doctor Rainey Elected Ky. Jaycee President

Fred Rainey, M.D., Elizabethtown, was elected president of the Kentucky Junior Chamber of Commerce at the May 18 annual meeting held this year at Paul Blazer High School in Ashland.

Doctor Rainey has served as KSMA District Legislative Key Man for the 4th Congressional District, and has served as a member of the board of trustees of KEMPAC. He is a 1955 graduate of the University of Tennessee College of Medicine.

Also elected at the meeting were Gene Landolt, Murray, international director, and Melvin Duke, Hardinsburg, internal vice-president.

Rural Loan Fund Trustees Approve Ten Applicants

The trustees of the Rural Kentucky Medical Scholarship Fund recently approved ten new applicants for first loans in the amount of $1,200 each. The same amount was approved for second, third, and fourth loan applicants who are recipients now in medical schools. This was an increase of $200 over last year.

At the May 1 meeting, held in the Board Room of the KSMA Headquarters, C. C. Howard, M.D., Glasgow, was re-elected Chairman of the Scholarship Board of Trustees, a position he has held since the launching of the scholarship loan program in 1946.

As is his custom, Doctor Howard invited a recipient of the Fund, presently out in practice, as his guest at the luncheon held during the meeting. This year the trustees honored Norman K. Kirby, M.D., Burkesville, and Mrs. Kirby.

MEDICAL SCHOOL NEWS

U. of L. to Unify Teaching At Jewish and General

A program to eventually unify the teaching of internal medicine at Jewish and General Hospitals in Louisville was announced recently. Beverly T. Towery, M.D., chairman of the department of medicine at the University of Louisville School of Medicine, will supervise the overall integrated teaching programs at both hospitals.

Angelo Ciliberti, M.D., will come to Louisville in August as director of the program at Jewish Hospital. He now holds a similar position at the United States Naval Hospital in Portsmouth, Va. Doctor Ciliberti will be appointed as a full-time faculty member at the School of Medicine, specifically designated to direct the expanded program at Jewish.

The program is designed to offer senior students, interns and residents at U. of L. the chance to work with private patients at Jewish, as well as the traditional training now received with indigent patients at General. Such a program, it is hoped, will attract more medical-school graduates to U. of L. for postgraduate training. For some time U. of L. has had working relationships with Norton Memorial Infirmary for postgraduate training in psychiatry and with Children's Hospital for pediatrics.

Medical School Gets 2 Grants

Two grants totaling $32,575 were given to the University of Louisville School of Medicine recently for direct support and for medical scholarships.

The National Fund for Medical Education, New York, granted $30,075 in unrestricted funds for operating costs and the teacher budget. The school also received $2,500 from the Medical Foundation of the Jefferson County Medical Society to be used for merit scholarships by the U. of L. admissions and review committee. $500 of this amount is in the form of a bequest from Mrs. Alice Snead Marshall Brooks as a memorial to her father, the late Ewing Marshall, M.D.

The House of Representatives recently approved a bill that would provide $205,700,000 for construction grants and student loans for medical and dental schools. Adoption of the bill by the Senate would be of benefit to the University of Louisville School of Medicine, since construction of a new medical-dental instructional building depends on the program which would provide for federal funds to cover half the cost of the building.

Tuition Raised for Nonresidents

Tuition for University of Louisville nonresident students will be raised $200 a year, according to a recent announcement by U. of L. President Philip Davidson, Ph.D. Tuition for medical and dental students will remain the same.

Rental on medical-dental apartments will be raised $5 a month. Efficiency apartments will rent for $80, one-bedroom apartments for $90 and two-bedroom $100. Single rooms in the medical-dental apartment building will go up from $275 to $300 a year.

Frank Falkner, M.D., professor and chairman of the department of pediatrics, and Steven Vandenberg, Ph.D., associate professor of child development research, both of the U. of L. School of Medicine, addressed a symposium on child development sponsored by the Louisville Child Guidance Clinic, held May 24-25 at the Medical Arts Building in Louisville.

The School of Medicine at U. of L. has recently announced the following faculty changes: appointment of Ronald Cravens Kelsay as instructor in community health, and Miss Marsha M. Blatt as instructor in ophthalmology; promotion of Grover Sanders, M.D., to assistant professor of medicine, Milton Diamond, Ph.D., to assistant professor of anatomy, Austin Bloch, M.D., to assistant professor of medicine, William C. Buschemeyer, M.D., to associate professor of medicine, Eugene E. Woodside, assistant professor of microbiology; and the resignation of Miss Pauline Klinger as assistant professor of psychology.

Frank Falkner, M.D., has been promoted to professor of pediatrics, William H. Marshall, M.D., to assistant professor of surgery and Price Fellow in Surgical Research. Richard C. McPherson, M.D., has been promoted to assistant professor of surgery, and Foster D. Coleman, M.D., to associate professor of medicine.

A grant of $1,000 was presented to the University of Louisville School of Medicine by the U.S. Steel Foundation, Inc., at a luncheon at the Sheraton Hotel in Louisville May 17. This grant was part of $24,000 given to 15 Kentucky colleges and universities as a part of a national program to aid education.

$100,000 Awarded To U.K. For Pharmacology Unit

The University of Kentucky College of Medicine was recently given a $100,000 five-year grant for the establishment of a section of clinical pharmacology in the department of medicine. The award was made by the Burroughs Wellcome Fund.

Harris Isbell, M.D., recently appointed professor of medicine, will direct the unit. Doctor Isbell will organize and conduct a course in therapeutics, including the application, mechanism, side effects, evaluation and effectiveness of drugs. He will also teach internal medicine and instruct in the department of pharmacology.

Student Inducted At SAMA Meeting

Ballard Wright, a junior at the University of Kentucky College of Medicine, was inducted into the U.S. Air Force in a special ceremony at the 13th annual meeting of the Student American Medical Association in Chicago May 1-5. Mr. Wright, president of the Student AMA at U.K., was notified of his acceptance in the Air Force-sponsored senior medical student program while serving as a delegate from the U.K. SAMA Chapter at the meeting.

Induction ceremonies were arranged to take place during the session.

Joseph Engelberg, Ph.D., assistant professor of physiology at U.K.'s College of Medicine, received a three-year, $12,500 financial grant from Lederle Laboratories in a ceremony April 18 in Atlantic City honoring his devotion to the teaching of medicine. Doctor Engelberg is the second such award recipient from U.K. Kingsley M. Stevens, M.D., associate professor of medicine, received a three-year grant in 1960.

Glenn U. Dorroh, M.D., Lexington, presented the U.K. Alumni Association's Faculty and Teaching Awards on April 26 at the dinner following a day of dedication ceremonies at the University's new Chemistry-Physics building. Major guest speaker at the ceremonies was Dr. Glenn T. Seaborg, chairman of the Atomic Energy Commission.

Additional Appointments

The University of Kentucky College of Medicine has announced the recent appointment of Abraham Wikler, M.D., as professor in the department of psychiatry, and of William G. Malette, M.D., as assistant professor in the department of surgery. B. F. Brown, M.D., Frankfort, has been named assistant professor in the department of clinical pathology. Visiting research professor in the department of physiology and biophysics will be Arnold C. L. Hsieh, M.D., of the University of Hong Kong.

Seven Kentuckians Attend Legislative Conference

According to John C. Quertermous, M.D., Murray, chairman of KSMA's Council on Legislative Activities, Kentucky was represented by seven physicians at the AMA National Legislative Conference held at the Pick Congress Hotel in Chicago April 20-21.

Representing the state were J. C. Cantrill, M.D., Georgetown; Robert C. Long, M.D., Louisville; Roy Moser, M.D., Ft. Mitchell; David B. Stevens, M.D., Lexington; Donald M. Stevens, M.D., Ft. Thomas; Herman Wing, M.D., Louisville, and Bobbie R. Grogan, secretary to the KSMA Council on legislative activities. Due to illness in his family, Doctor Quertermous was unable to attend.

More than 500 physicians registered for the two-day meeting, an increase of 40% over former legislative conferences. George M. Fister, M.D., President of the AMA, stated that the conference was called to bring together AMA, state, and county society representatives for a definite and serious purpose. It would, he said, provide a forum for constructive evaluation of national legislation and practical problems and methods for dealing with these problems.

"Operation Hometown," a highly practical and workable plan for legislative activity at the County level, was explained, and a take-home package given to representatives. Doctor Quertermous said this kit would be brought to the attention of all county societies in Kentucky.

Cooperation Urged For PKU Testing Program in Ky.

Kentucky physicians are being urged by the State Department of Mental Health to cooperate in a program for the testing of all newborn infants for PKU (phenylketonuria).

According to the results of a nationwide survey recently released to the public, three states have passed legislation and others are stepping up programs to encourage routine hospital testing.

A report in the Wall Street Journal recently stated, "A pilot project sponsored by the Children's Brueau of the Department of Health, Education, and Welfare is demonstrating that a simple blood test can detect the disease in the first days of life, when retardation can be prevented by special diet."

Conductors of the recent survey, Mead Johnson Laboratories, Evansville, Ind., report that a program has been established in Kentucky for discovering infants afflicted with PKU, whereby all parents of newborn infants are sent test filter paper. The paper is exposed to the baby's urine, and then sent to Children's Hospital in Louisville for analysis.

Information regarding PKU testing may be obtained from the State Board of Health, Frankfort, Ky.

Doctor Hammond Appointed

Harold L. McPheeters, M.D., State Mental Health Commissioner, recently announced the appointment of Wylda Hammond, M.D., Lexington, as consultant to the Division of Mental Retardation. Doctor Hammond is the wife of Thomas L. Nelson, M.D., associate professor of pediatrics at the University of Kentucky College of Medicine in Lexington.

Since 1961 Doctor Hammond has served with the Kentucky State Department of Health as director of maternal, infant, preschool, and mental-retardation services. She is a former staff member of the University of California Medical Center, and served for ten years on the staff of Sonoma State Hospital in California.

Crusade Gives Grants to 3

Three grants totaling $14,000 were announced recently by the 1962 WHAS Crusade for Children. $10,000 went to the building fund of Handicapped Children, Inc., Louisville, for the construction of the cerebral-palsy school on Baxter Avenue.

The Council for Retarded Children of Pike County received $2,000 to assist in the operation of the Calvert School for Retarded Children. The remaining $2,000 is a contingency grant to United Cerebral Palsy of Greater Louisville to assist the launching of a pilot project next fall in training cerebral palsied children of preschool age so that they might enter regular school classes.

Michael Saxe Zeman, M.D., assistant professor of otolaryngology at the University of Louisville School of Medicine, has been elected a member of the American Laryngological, Rhinological, and Otological Society.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1963 Annual Meeting — Kentucky State Medical Association

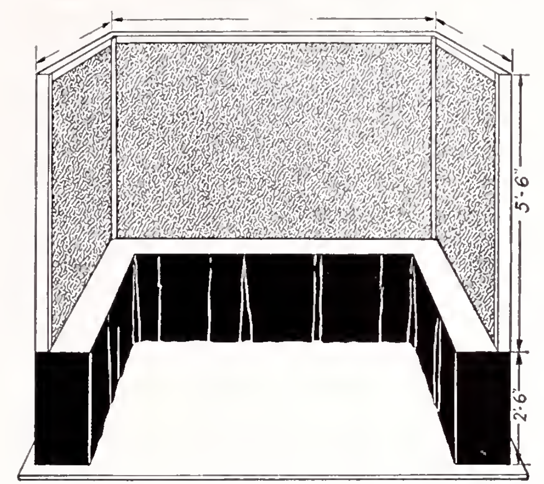
Phoenix Hotel — **Lexington, Kentucky** — **September 23, 24, 25, 26**

Fill Out and Mail to:

J. ALEX HALLER, M.D., Chairman
Committee on Scientific Exhibits
Department of Surgery
University of Louisville
511 S. Floyd Street
Louisville 2, Kentucky

Applications for space should be received before July 1, 1963

Dimensions and structure of KSMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: . . . .
2. Name (s) of Exhibitor (s): . . . .

   . . . .

   Institution (if desired): . . . .

   Mailing Address . . . .
3. Do you have a built-in exhibit? . . . .
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)

   Charts and Posters. . . . Photographs. . . . Drawings. . . . X-rays. . . .

   Specimens. . . . Moulages. . . . Other Material . . . .
   (Describe)
6. Booth Requirements:

   Amount of wall space needed? . . . .

   Back wall . . . . .Side walls . . . .

   Square feet needed? . . . .

   Shelf desired? (yes or no) . . . .
7. Has This Exhibit Been Exhibited Before? (yes or no) . . . .

Date . . . .
Signature of Applicant

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KSMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

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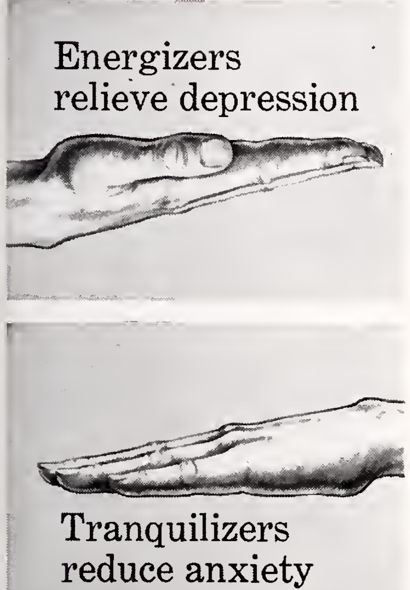
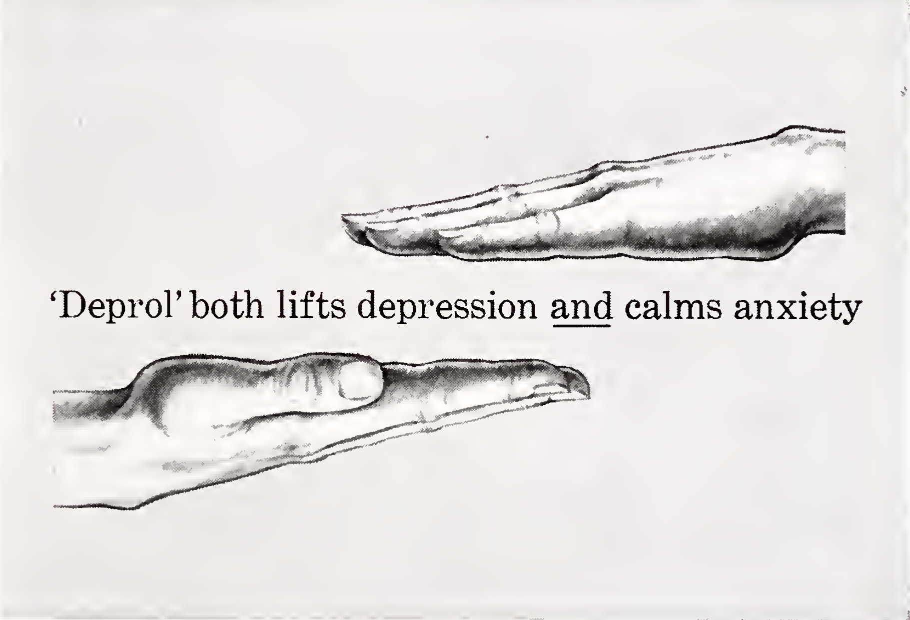
'Deprol' avoids these "seesaw" effects; it relieves both depression and anxiety. Moreover, it does not cause liver damage, psychotic reactions or changes in sexual function.

Slight drowsiness and, rarely, allergic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.





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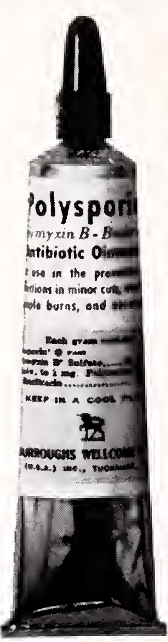

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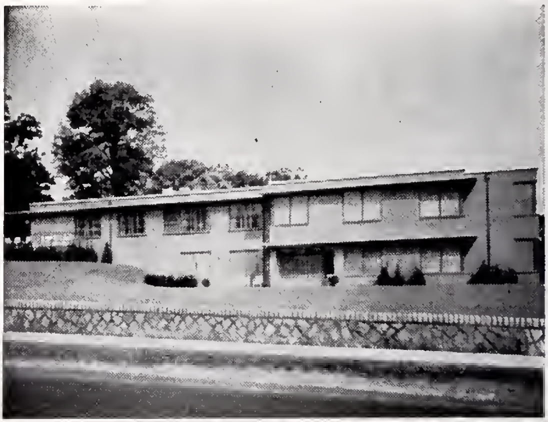

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Available: 200 mg. Caplets® (green colored, scored), 100 mg. Caplets (peach colored, scored), each in bottles of 100.

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References: 1. A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963. 2. Gruenberg, F.: Curr. Ther. Res. 2:1 (Jan.) 1960.

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Doctor Noer on Programs

Rudolph J. Noer, M.D., professor and chairman of the department of surgery at the U. of L. School of Medicine, delivered an oration in Surgery at the Illinois State Medical Society's 123rd Annual Convention at Sherman House in Chicago May 15. Doctor Noer's address was titled "Diverticular Disease of the Colon."

Doctor Noer also presented "A Critical Review of Cancer of the Breast" before the May 14 General Session of the Ohio State Medical Association Annual Meeting. On April 11 he spoke on "Chemotherapy of Neoplasms" at the University of Kentucky Medical Center auditorium in Lexington.

Three in Ky. Honored

The American College of Physicians recently named three Kentucky physicians among those designated as Fellows and Associates of the ACP. The announcement was made by Wesley W. Spink, president of the internist's group.

William W. Winternitz, M.D., associate professor of medicine at the University of Kentucky College of Medicine, was elected as a Fellow of the ACP. Selected as associates were James R. Dade, M.D., Hopkinsville, and William R. Gray, M.D., Louisville, instructor in medicine at U. of L.

The Harlan UMWA Memorial Hospital shown above is one of the key institutions included in the negotiations for 10 hospitals now being conducted by the United Presbyterian Church.

KSMA Relates Basis for Cooperation With Presbyterian Group In Proposed Operation of UMWA Hospitals

There are two apparent hurdles faced by the United Presbyterian Church that must be resolved before completing negotiations for the 10 hospitals now operated by UMWA's Memorial Hospital Association, according to a spokesman for the National Board of Missions of the church, as we went to press.

Plans are being made for the complete transfer of the five hospitals located at Harlan, Hazard, McDowell, Middlesboro, and Whitesburg no later than October 1, 1963. The remaining hospitals, at South Williamson and Pikeville, Ky., Beckley and Man, W. Va., and Wise, Va., are expected to be transferred by July 1, 1964.

One of the hurdles mentioned was the approval of a loan by the Area Redevelopment Administration, an agency of the U.S. Department of Commerce. The second interest relates to developments that may result from a proposed special session of the Kentucky State Legislature.

The spokesman for the Presbyterian group told the KSMA that there are tentative plans being made for the development of a comprehensive and intensive educational program communities throughout Eastern Kentucky. The purpose of this proposed program would point out to physicians and the community in general that the Presbyterians are trying to desocialize medicine, avoid the corporate practice of medicine, and make these into community hospitals run by and for the communities.

In a special meeting of the KSMA Board of Trustees in Lexington April 21, Mr. Robert Barrie, a representative of the National Board of Missions, explained the general aims of the Presbyterian group and developments to that time.

Guests at the meeting included F. J. L. Blasingame, M.D., Chicago, executive vice-president of the AMA, and James Holloway, M.D., Lexington, chairman of the KSMA Hospital Committee, together with a number of physicians from the area in which the UMWA hospitals are located.

After an executive session, the KSMA Board of Trustees announced the following action: that *The Kentucky State Medical Association wishes to commend the Presbyterian Church for their humanitarian effort to keep these hospitals in operation. Furthermore, we feel that the members of the KSMA will provide medical care to the patients in these hospitals provided:*

1. That the patient has free choice of hospital and physician

2. That medical service be on a fee for service basis

3. That there are no physicians' offices in these hospitals

The Board of Trustees of the KSMA stands ready to cooperate in the future with the concerned parties in implementing this program in keeping with the above policies.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

Submit Dates For Calendar Now

Throughout the year, many medical organizations are setting dates for meetings, arranging for speakers, planning programs, etc.

The Postgraduate Medical Education office of the Kentucky State Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Educational Opportunities" calendar in The Journal. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KSMA Postgraduate Medical Education Office, 3532 Janet Avenue, Louisville 5, Ky.

In Kentucky

JULY

10 — London Seminar, Kentucky Academy of General Practice, Sue Bennett College, London, Ky.

26-27 — Park Seminar, Kentucky Academy of General Practice, Jenny Wiley State Park, Prestonsburg, Ky.

AUGUST

18 — Bluegrass Symposium, Kentucky Academy of General Practice, Phoenix Hotel, Lexington, Ky.

28-29 — Cave Area Seminar, Kentucky Academy of General Practice, Diamond Caverns Hotel, Park City, Ky.

SEPTEMBER

23-26 — KSMA Annual Meeting, Phoenix Hotel, Lexington, Ky.

OCTOBER

10 — Maysville Seminar, Kentucky Academy of General Practice, Mason City Health Building, Maysville, Ky.

18-20 — Pediatrics Postgraduate Course, Children's Hospital, Louisville, Ky.

23 — Review of Current Problems in Obstetrical Anesthesia, U. of L. School of Medicine, Louisville General Hospital, Louisville, Ky.

24 — Rural Health Conference, Jenny Wiley State Park, Prestonsburg, Ky.

NOVEMBER

6 — Annual Fall Clinical Conference, Lexington Clinic, Lexington, Ky. Morning: Rheumatoid Arthritis; Afternoon: Specialized Diagnostic Techniques.

9 — Regional American College of Physicians, Holiday Inn, Lexington, Ky.

DECEMBER

19 — Annual Postgraduate Seminar, Norton Memorial Infirmary, Louisville, Ky.

Surrounding States

JUNE

13-17 — American College of Chest Physicians, Ambassador Hotel, Atlantic City, N.J.

16-20 — Annual Meeting, American Medical Association, Auditorium & Convention Hall, Atlantic City, New Jersey

17-21 — 5th Annual refresher course in Diagnostic Roentgenology, University of Cincinnati College of Medicine, Cincinnati, Ohio.

24-27 — American Orthopaedic Association, The Homestead, Hot Springs, Va.

SEPTEMBER

20-21 — National Rural Health Conference, Arlington Hotel, Hot Springs, Ark.

OCTOBER

5-10 — American Academy of Pediatrics, Palmer House, Chicago, Ill.

5-11 — Annual Otolaryngologic Assembly, University of Illinois College of Medicine and Illinois Eye and Ear Infirmary, Chicago, Ill.

24-26 — Annual Course in Postgraduate Gastroenterology, American College of Gastroenterology, Shoreham Hotel, Washington, D.C.

28-Nov. 1 — American College of Surgeons, Brooks Hall, San Francisco, Calif.

NOVEMBER

11-15 — American Public Health Association, Kansas City, Mo.

18-21 — Southern Medical Association, Municipal Auditorium, New Orleans, La.

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County Society Reports

McCracken

Joseph Warren, M.D., of the Rheumatologist-Rehabilitation Service at the University of Kentucky College of Medicine, presented the scientific program at the April meeting of the McCracken County Medical Society. The Society gave a unanimous vote of thanks to the Polio Committee for its outstanding work in the immunization program. A committee is being set up for the purpose of studying possible distribution of the money remaining from the immunization program.

The members approved a motion that J. V. Pace, M.D., Paducah, be strongly recommended by the McCracken County Medical Society to the nominating committee of the Board of Trustees for renomination as a Delegate from KSMA to the House of Delegates of the AMA. Doctor Pace's term will expire next year. Members were also reminded to consider outstanding lay citizens for nomination for the KSMA awards.

Henderson

Thomas Marshall, M.D., Louisville, was guest speaker at the Henderson County Medical Society meeting at the Soaper Hotel in Henderson on May 6. Doctor Marshall addressed the members on "Causes of Pain in Arm and Shoulder."

Student AMA

U.K. Chapter President Describes SAMA National Convention

The Kentucky State Medical Association underwrote the expenses of our delegates to the 1963 Student American Medical Association National Convention. The convention was held in Chicago, May 2-5. We are very grateful to the state society for enabling us to attend.

The convention was attended by myself, and Franklin C. Belhasen, class of '64. We arrived in Chicago May 1, and were embraced by a whirlwind of events until our departure on the 5th.

We were addressed by a number of outstanding speakers on topics ranging from politics to religion, which, as I'm led to understand, is not unusual. Nor was our medical education neglected, as there was an excellent scientific symposium. Among the many distinguished speakers were: Albert E. Ritt, M.D., President, American Academy General Practice; George M. Fister, M.D., President, American Medical Association; Walter Alvarez, M.D., Mayo Clinic; Michael DeBakey, M.D., Professor of Surgery, Baylor University; and Corbett Thigpin, M.D., Atlanta.

The House of Delegates concerned itself with far-ranging matters, all of which affected the student. There were over thirty resolutions submitted to the delegates for consideration. Among those problems discussed were: the shortage of general practitioners, and the failure of medical schools to develop this type of physician; income tax exemption for medical education; Cuban physician placement; and Senate Bill S-533, the antivivisection legislation. The resolution drawing most interest and controversy dealt with HR-12, the House bill which proposes, among other things, federal loans to medical students. Everyone agreed that more aid was needed for medical students than was currently available, but many decried the direct participation of the government in the resolution of this need.

Medical Student Wives, the University of Kentucky chapter of the Women's Auxiliary of the Student American Medical Association, was represented at the convention by Mrs. Norman Nedde and Mrs. Stanley Williams, and was awarded second place as "Chapter of the Year." Fifty chapters were competing for the award which is based on programs and projects of the past year. The first place award was won by the chapter from the University of Arkansas.

Ballard Wright
President

U. of L. SAMA President Reports Chapter's Accomplishments

The time is appropriate to reveiw the accomplishments of our University's SAMA of the past year.

These include the traditional Freshmen Orientation, the Student Physician Four Year Friendship Program, student holiday convocations, professor evaluation with selection of outstanding preclinical and clinical professors, and publication of the pocket size student directory.

This year, upon our recommendation, the Gross Anatomy Laboratory was dedicated to the late Dr. Arch E. Cole, a Dean's Student Advisory Committee was appointed, a solicitation committee to work with Dr. Wagner in the fall was selected, and a publicity representative was elected.

The University of Louisville was represented this school year by SAMA members at the Annual KSMA Meeting, the 13th Annual Interim Meeting of the KSMA, and the National SAMA Convention. Definite plans have been made to obtain student lockers in Louisville General Hospital, and several committees have been selected to function throughout the summer months.

We are indeed happy with the achievements of our chapter this year, and are looking forward to an even better year next year. The election of next year's SAMA officers will be reported in the next issue along with some facts concerning our trip to the National Convention.

Jerry B. Buchanan, President
U. of L. Chapter, SAMA

U. of L. Graduate Gets Deanship

Walter G. Unglaub, M.D., a 1942 graduate of the University of Louisville School of Medicine, was recently appointed associate dean of Tulane University School of Medicine in New Orleans. Doctor Unglaub was also named director of the division of graduate medicine at the school.

In Memoriam

WILLIAM H. KEELING

Bloomfield, Ky.

1918 - 1963

William Hollen Keeling, M.D., 44, Bloomfield general practitioner, died unexepctedly on May 8 at Flaget Memorial Hospital in Bardstown. He had practiced in Bloomfield for 17 years. Doctor Keeling, a 1943 graduate of the University of Louisville School of Medicine, was a past president of the Nelson County Medical Society.

JOHN F. STANDARD

Elkton, Ky.

1884 - 1963

John Ford Standard, M.D., general practitioner at Elkton for 52 years, died after a heart attack on May 12 at Jennie Stuart Hospital in Hopkinsville. Doctor Standard, a native of Todd County, attended Vanderbilt University and was graduated in 1910 from the College of Medicine and Surgery in Chicago.

ROBERT L. COLLINS, M.D.

Hazard, Ky.

1879 - 1963

Robert Lee Collins, M.D., 83, retired Eastern Kentucky surgeon died May 20 at his home in Hazard. Doctor Collins, who served as the first surgeon for the Frontier Nursing Service, was a former secretary of the Perry County Medical Society, and a 1907 graduate of the Louisville College of Medicine. He was the first recipient of the Howard Award in Kentucky, a presentation now made annually to an outstanding physician in the state.

LOUELLA LIEBERT, M.D.

Louisville, Ky.

1916 - 1963

Louella Hudson Liebert, M.D., 46, Louisville general practitioner, died May 5 at the Veteran's Hospital in Marion, Ind., after an illness of several months. Doctor Liebert, a 1940 graduate of the University of Louisville School of Medicine, served in the Army Medical Corps during World War II.

G. W. WHITE, M.D.

Henderson, Ky.

1886 - 1963

George W. White, M.D., 77, Henderson otolaryngologist, died unexpectedly at his home April 15. He had retired from active practice in 1960. Doctor White, a 1908 graduate of the Louisville and Hospital College of Medicine, began his practice in Henderson in 1919.

Doctor Sanders Heads KTS

Grover Sanders, M.D., Louisville, was installed as new president of the Kentucky Thoracic Society on April 23 at the meeting of the society in Lexington. Jerome Cohn, M.D., assistant professor of medicine at the University of Kentucky College of Medicine, was named president-elect for 1964.

Other officers elected during the two-day meeting were N. A. Saliba, M.D., medical director of the State Tuberculosis Hospital in Louisville, secretary-treasurer; and William H. Anderson, M.D., Harlan, representative councilor to the American Thoracic Society.

Doctor McPheeters Testifies

Kentucky Mental Health Commissioner Harold L. McPheeters, M.D., testified March 27 before Congressional committees on the bills which would implement the President's message on mental health and mental retardation. Doctor McPheeters was one of several mental health experts appearing before the subcommittee on Public Health and Safety, of the House Committee on Interstate and Foreign Commerce.

Old KSMA Home Sold

The old State Department of Health Building at 620 South Third Street in Louisville, the former home of the Kentucky State Medical Association, has been sold to a wholesale distributor and merchandiser, it was announced recently.

From 1937 until 1957, when the headquarters office was moved to the Medical Arts Building, KSMA was housed in the Third Street offices, occupied at one time by the Federal Land Bank. The present KSMA Headquarters building has been in use since January 1962.

Herbert R. Booth, M.D., has begun general practice at Florence, Ky., in association with **Floyd G. Poore, M.D.**, after completing his internship at St. Elizabeth Hospital in Dayton, Ohio. Doctor Booth is a 1962 graduate of the University of Louisville School of Medicine.

Thomas E. Campbell, M.D., has opened an office in the Medical Towers in Louisville for the practice of opthalmology. Doctor Campbell, a 1958 graduate of the University of Louisville School of Medicine, recently moved to Louisville from Birmingham, Ala., where he completed a preceptorship in opthalmic plastic surgery. He completed a residency at Louisville General Hospital.

The late **Louella H. Liebert, M.D.**, of Louisville, who died May 5, left $1,000 to the University of Louisville School of Medicine scholarship fund, by her will probated recently in Jefferson County Court. Doctor Liebert was a graduate of the U. of L. School of Medicine.

PUBLIC HEALTH PAGE

Laboratory Diagnosis of Viral And Rickettsial Diseases*

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

THE Virus Unit of the Division of Laboratory Services was established in 1956 in order to provide reference laboratory facilities for the diagnosis and epidemiological study of viral and rickettsial diseases. Tests presently available from this laboratory include virus isolation from clinical specimens and serological procedures for the detection of specific antibodies against various viral and rickettsial agents.

The successful isolation of a viral agent from clinical material depends upon the inoculation of a susceptible host with an appropriate clinical specimen containing the viral agent in question. The clinical specimen should be obtained as early as possible in the acute stage of illness and transported to the laboratory by the most rapid means available. Unless the specimen can be delivered to the laboratory within a few hours it should be quick frozen, packed in dry ice and transported in the frozen state. Dry ice releases CO_2 which is deleterious to most viral agents, therefore, it is extremely important that the screw cap of the specimen vial be securely tightened to prevent the absorption of CO_2.

After special preparation, a portion of the clinical specimen is used to inoculate an appropriate host system. Living tissue such as chick embryos, tissue culture or susceptible white mice must be used, as viral agents are incapable of propagating outside living cells. The host system is examined periodically for evidence of viral multiplication and the viral isolate is identified by serological methods.

Failure to isolate a specific virus from a specimen dces not rule out that agent as a possible cause of the illness in question and the isolation of a virus dces not necessarily mean that the current illness is due to that virus. The results of virus isolation attempts must be correlated with the clinical, epidemiological and serological data available.

Infection with most viral and rickettsial agents stimulates the production of sepcific antibodies which may be detected by various serological procedures including complement fixation, hemagglutination-inhibition and neutralization tests. Since many individuals already have antibodies against certain viral and rickettsial agents because of vaccination or previous contact with that agent, the finding of antibodies in a single serum sepcimen does not provide significant information regarding the etiology of the illness in question. A definite rise in antibody titer (four-fold or higher) from the acute stage of the disease to convalescence, however, is usually significant. The first, or acute specimen, should be collected as early in the illness as possible and the second, or convalescent specimen, should be collected three to four weeks later.

A thorough history is extremely important. The laboratory will be able to give more efficient service if every item of the submission form is completed and the suspected virus group is indicated. Blanket requests for "viral studies" should not be made.

Viral diagnostic laboratory procedures are frequently of limited value to the individual patient, as many of these tests require weeks or even months to complete, but the epidemiological significance of such tests may be extremely great. Many of these tests are time consuming and costly. The Division of Laboratory Services is anxious to provide viral and rickettsial diagnostic facilities in instances where a contribution to the health of the community may be made, but viral and rickettsial procedures should not be requested without reasonable justification.

The State Department of Health Publication "Laboratory Services", which is available from Local Health Departments throughout the state, should be consulted for further details regarding the collection and submission of specimens for diagnostic procedures. Suitable specimen mailing containers are also available from Local Health Departments. Further consultation may be obtained by contacting the Director, Division of Laboratory Services, Kentucky State Department of Health.

**This article was prepared by B. F. Brown, M.D., M.P.H., director, Division of Laboratory Services, Kentucky State Department of Health, 275 East Main Street, Frankfort, Kentucky.*

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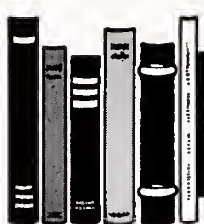

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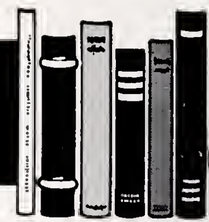

GASTROENTEROLOGY: Volume I (Second Edition) edited by Henry L. Bockus, M.D.; published by W. B. Saunders Co., Philadelphia; 1963; 958 pages; price, $25.

The second edition of Bockus' *Gastroenterology* seems destined to become the classic reference work on the subject, just as his first edition was 20 years ago. The 31 contributors to this volume are present or former associates of Doctor Bockus at the University of Pennsylvania Graduate School of Medicine. Two of the contributors, Arthur M. Schoen, M.D., and John H. Willard, M.D., now practice in Kentucky.

Volume I includes chapters on examination of the patient, affectations of the esophagus, stomach, and duodenal ulcer. Tables and diagrams are very effectively utilized. For example, there is a table giving the sodium and potassium content of the various antacids commercially available. Many color plates of photographs and drawings are included. Liberal use of roentgenograms increases the value of the book.

The chapters are authoritative and well written. References are included up to 1961. As expected, gastric and duodenal ulcer are extensively discussed in relation to pathophysiology, diagnosis, complications, and medical and surgical treatment. The role of roentgenography, certainly the primary method in diagnosis of these disorders, is discussed from point of view of weakness and strong-points.

Several chapters are devoted to the anatomy and physiology of the esophagus. This is a segment of the gastrointestinal tract which has been bypassed in most research efforts. Esophagitis and esophageal hiatus hernia are thoroughly discussed. A very interesting discussion of the diagnosis, significance, and treatment of lower esophageal rings, so-called Schatzki's rings, is included. There are many unanswered questions regarding these rings, but all evidence to date is included.

Volume II is to be on the market later in 1963 and Volume III is scheduled for printing early in 1964.

The authors' stated purpose of the text, "a helpful companion of the gastroenterologist, the internist and the abdominal surgeon, and a work of reference for the general practitioner and the physician interested in research in gastroenterology," seems fulfilled. However, the price of $25 for the volume unfortunately puts it out of reach for many of us.

F. Norman Vickers, M.D.

GYNECOLOGY: by Langdon Parsons, M.D., and Sheldon C. Sommers, M.D.; published by W. B. Saunders Co., Philadelphia; 1962; 1250 pages; price, $20.

This textbook by an outstanding gynecologist and pathologist will be a valuable addition to libraries as a reference work. Its use by the practitioner will probably be limited.

It is organized in an unusual manner—by age groups with seven divisions ranging from infancy to old age. In some ways this division is helpful, such as the excellent section on childhood gynecological problems. On most of the subjects, however, the strict adherence to age groups leads to a great deal of repetition; for example, vaginitis, carcinoma, sarcoma, abnormal bleeding, and breast diseases are discussed in several different chapters.

The manner of presentation is more like a lengthy oral dissertation than a concise written text; introductions and summaries occur frequently, and, therefore, this reviewer found some of the material cumbersome.

A reader unfamiliar with the subject could be misled by several statements which are lacking in scientific evidence yet are interspersed with well documented facts. For example: 1., P.380, "There is ample evidence . . . that vitamin E is important in maintaining a pregnancy in patients who give a history of habitual abortion"; 2., P.383, statements are made that lead one to believe that a weakly positive or a negative pregnancy test shows a threatened abortion to be inevitable. (Many a fine child would be curetted away if this rule were followed.) 3., P.456, in operating for polycystic ovaries, "the operator provides excellent cancer prophylaxis at an early age." (This highly theoretical statement comes from the similarity of polycystic ovaries to the stromal hyperplasia which sometimes occurs in women with carcinoma of the endometrium and the breast.)

There are many pearls to be found; witness on Page 1056 the advice is that when estrogen therapy is to be given for extended periods it should be interrupted for five days each month. Other gems are found in the discussions of precocious puberty, amenorrhea, ruptured tubo-ovarian abscess, and the RR and SR phenomenon.

The chapter on carcinoma of the cervix is one of the most brilliant to be found anywhere. Other outstanding parts of this book to me are the sections on hormones, genetics, marriage counseling and the carefully organized bibliographies at the end of each chapter.

Harold W. Baker, M.D.

News Items

Asa Barnes, M.D., Louisville, was named president of the Kentucky Tuberculosis Association at the close of the Association's annual meeting in Lexington on April 26. **E. N. Maxwell, M.D.,** and **T. A. Woodson, M.D.,** both of Louisville, were elected first and third vice-presidents, respectively. **E. R. Gernert, M.D.,** Louisville, was named treasurer. At the same meeting, the Kentucky Thoracic Society named **Kurt W. Deuschle, M.D.,** Lexington, to its executive committee.

W. Burford Davis, M.D., Louisville thoracic surgeon, was recently honored by his Alma Mater, Centre College, for his service to Centre and to mankind. He was honored at the first annual Alumni Recognition Convocation held April 26 on the Danville campus. Doctor Davis was elected president of the alumni association prior to the convocation.

Howard I. Frisbie, M.D., Stanford, was presented with the "Outstanding Citizen of the year" award at the annual Stanford Chamber of Commerce Membership Banquet April 16. Doctor Frisbie, a businessman and civic leader, was given the second such award presented by the group.

William F. O'Donnell, Jr., M.D., Hazard, was recently named by the board of City Commissioners to the Hazard Public Housing Commission.

Kentucky State Medical Association President David M. Cox, M.D., was represented by President-Elect **George P. Archer, M.D.** at the May 15 reception given by the Ohio State Medical Association in honor of retiring OSMA Executive Secretary **Charles P. Nelson.** Mr. Nelson has been executive secretary of the OSMA for 35 years. He will retire in December of this year. Mr. Nelson has been in Kentucky often to attend numerous medical meetings.

Karl E. Yaple, M.D., chief of pediatrics at Harlan Memorial Hospital, Harlan, Ky., was named man of the year by the Harlan County Junior Chamber of Commerce at the April 15 meeting of the Chamber. In addition, Doctor Yaple was elected president of the group at the same meeting. The Jaycee's Distinguished Service Award for 1962 was presented to Doctor Yaple recently in recognition of his efforts in the Sabin Oral Sunday program last fall.

Two U. of L. graduating seniors departing for internships in other cities take with them former secretaries from the KSMA Headquarters Office. Mrs. Jack Wallace, who left KSMA in October 1962 after more than three years in the Headquarters Office, will be going to St. Louis, where her husband, **Jack Wallace, M.D.,** will intern at Barnes Hospital. Dallas, Texas, is the destination of **Jim Walker, M.D.,** and his new bride, the former Patricia Nall, who had been with KSMA approximately a year. Doctor Walker will intern at Parkland Memorial Hospital in Dallas.

William A. Weldon, M.D., Glasgow, was awarded an honorary Doctor of Science degree by Kentucky Wesleyan College on May 27. Doctor Weldon, a 1916 graduate of Vanderbilt University School of Medicine, attended the Academy of Kentucky Wesleyan College in 1908 and 1909. Doctor Weldon has been active in civic, recreational and educational activities in Glasgow.

Charles I. Schwartz, M.D., psychiatrist and chief of staff at the Veteran's Administration Hospital in Lexington, was honored recently in that city as the Kentucky doctor who has done most to assist handicapped persons in finding jobs and leading useful lives. He was honored at the annual luncheon meeting of the Kentucky Commission on Employ the Handicapped.

Cooley L. Combs, M.D., Hazard, was recently appointed by Governor Bert Combs to the Council on Public Higher Education in Kentucky. Doctor Combs is a member of the Hazard City School Board, and in 1959 served as president of the Kentucky School Board Association.

Gradie R. Rowntree, M.D., Louisville, was among the speakers addressing the 18th annual Kentuckiana Safety Conference and Exhibit May 21-22 at the Kentucky Hotel in Louisville. The Louisville Safety Council and 36 organizations sponsored the meeting.

New Books Featured

W. B. SAUNDERS COMPANY features the following new editions in their full page advertisement appearing elsewhere in this issue:

BEESON and McDERMOTT — CECIL-LOEB TEXTBOOK OF MEDICINE
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Insurance Forms Available

Approximately 20,000 copies of the Short Claim Insurance Form, approved by the AMA and the Insurance Council, have been sent to KSMA members during the past six months. This new "short form" was adopted by the KSMA House of Delegates during the 1962 Annual Meeting.

John Dickinson, M.D., Glasgow, Chairman of the KSMA Insurance Committee, states that his committee highly recommends the use of this standardized form. A free supply of the forms is available by writing the KSMA Headquarters Office.

Notice to Women Physicians

All women physicians attending the AMA in Atlantic City are invited to rest in the Hospitality Room number 2 on the Mezzanine floor in the convention hall. On June 18 The American Medical Women's Association is serving tea in the Hospitality Room. All women physicians and their friends are invited.

Walter A. Kirchner, M.D., has become associated with the Trover Clinic in Madisonville, Ky., for the practice of pediatrics. Doctor Kirchner, a 1944 graduate of the University of Louisville School of Medicine, was formerly located in Louisville.

Don Allen Wheeler, M.D., Cumberland, Ky., has begun general practice at Lynch, Kentucky in association with the Cumberland Valley Medical Group. Doctor Wheeler, a native of Pikeville, Tenn., is a 1961 graduate of the University of Tennessee College of Medicine.

(Continued from page 497)

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June is National Dairy Month

All KSMA members are urged by David M. Cox, M.D., KSMA president, to observe National Dairy Month June 1-30. Dairy Month opened officially on June 1 at the state Fairgrounds in Louisville in conjunction with the National Jersey Cattle Club Sale and Show.

In Kentucky, 65 counties will participate in the program by observation of local Dairy Days. Jane Harrison, Farmington, Ky., this year's Kentucky Dairy Princess, will make appearances during a number of local programs.

In reply to Miss (Rachel) Carson's assertion that there have been many deaths due to insecticides . . . there has never been one medically documented death due to the *proper* use of insecticides. Deaths due to improper use, according to the U. S. Department of Agriculture, totalled 89 last year. Improper use of any substance can cause harm or even death. For example, aspirin alone accidentally kills about 150 a year, most of them children. No one has yet suggested we do away with aspirin—or with automobiles, which kill thousands of people. Editorial in *Journal of Iowa Medical Society*, March 1963.

After three years of ordeal in the harsh glare of often destructive and politically-motivated "investigation", it would not be surprising if the nation's pharmaceutical manufacturers took a sour view of the legislation that has been enacted as a result of all this investigative activity. But the fact is that, by and large, manufacturers have reacted to the new federal drug law in a statesmanlike manner that reflects a long-range concern with the public interest more than it reflects any short-sighted fear of declining profits. —Editorial in *New Medical Materia*, Feb. 1963.

The most striking feature about the U. S. Federal Government today is its size. The number of Federal employees has reached a peacetime high of 2.5 million. The cost of the Federal civilian payroll rose to $15 billion in 1962 and is expected to total $15.6 billion by June 30, 1964. Thirty states have more Federal employees than state employees. It is estimated that if present trends continue, every one of us will be working for the government by the year 2000.—Austin Smith, M.D., President, Pharmaceutical Manufacturers Association, to Advertising Club of St. Louis, Mo., Feb. 6, 1963.

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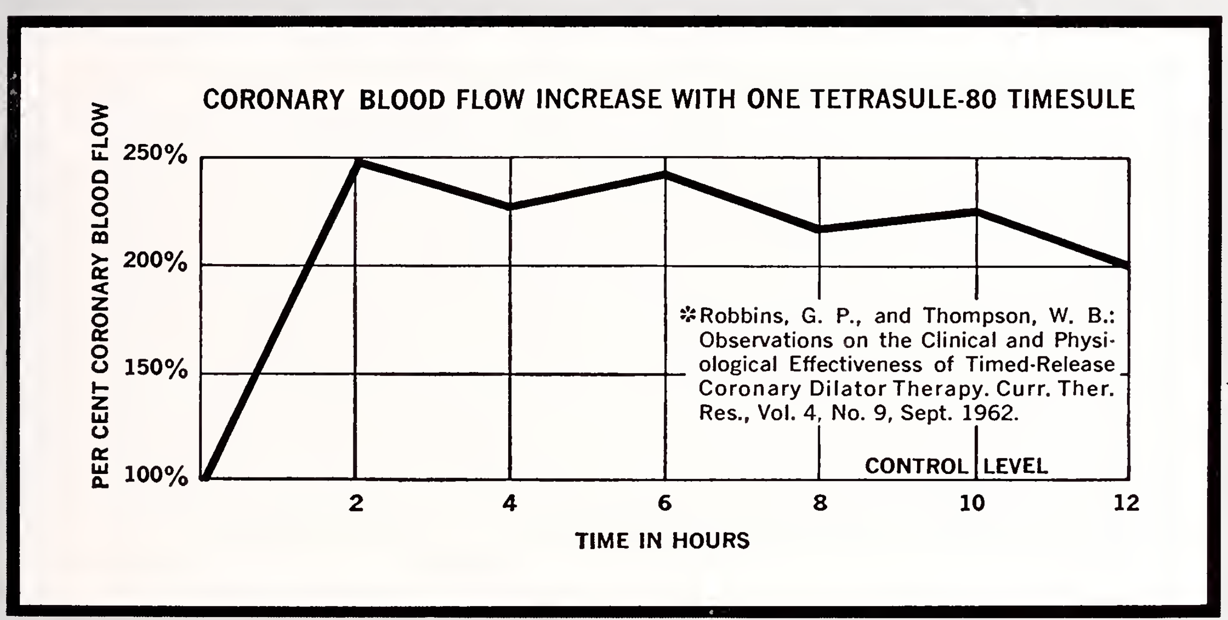

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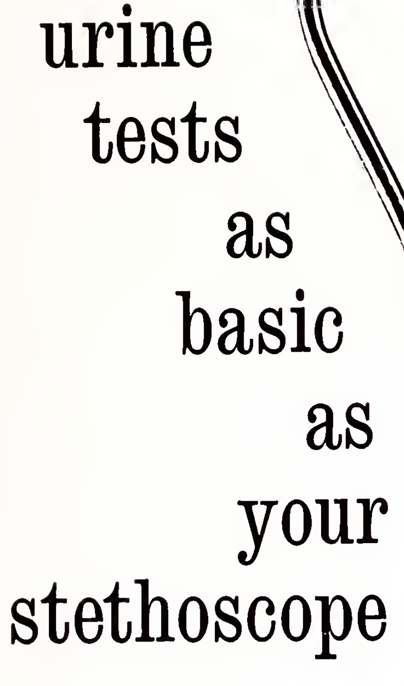

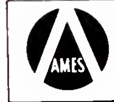

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DOSAGE: **Oral** – Usual adult dose in mild to moderate anxiety and tension is 5 or 10 mg, 3 or 4 times daily; in severe anxiety and tension, 20 or 25 mg, 3 or 4 times daily. **Parenteral** – To control acute conditions, the usual initial adult dose is 50 to 100 mg I.M. or I.V.; not more than 300 mg should be given during a 6-hour period. ☐ SIDE EFFECTS: **Oral** – Drowsiness and ataxia, usually dose-related, have been reported in some patients – particularly the elderly and debilitated. Paradoxical reactions, **i.e.**, excitement, stimulation, elevation of affect and acute rage, have been reported in psychiatric patients; these reactions may be secondary to relief of anxiety and should be watched for in the early stages of therapy. Other infrequent dose-related side effects have included isolated instances of minor skin rashes, minor menstrual irregularities, nausea, constipation, increased and decreased libido. **Parenteral** – Following parenteral administration some patients may become drowsy or unsteady. The injectable form has occasionally produced mild, transitory fluctuations of blood pressure. ☐ PRECAUTIONS: **Oral** – In elderly, debilitated patients, limit dosage to smallest effective amount to preclude development of ataxia or oversedation (not more than 10 mg per day initially, to be increased gradually as needed and tolerated). Until the correct maintenance dosage is established, patients receiving this agent should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Although this agent is a valuable aid in acute and chronic alcoholism, caution patients about possible combined effects with alcohol. Caution should be exercised in administering it to addiction-prone individuals. Careful consideration should be given to the pharmacology of any agents to be employed with Librium (chlordiazepoxide HCl) – particularly the MAO inhibitors and phenothiazines. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests may be advisable in protracted treatment. **Parenteral** – Parenteral administration is indicated primarily in acute states, and patients receiving this form of therapy should be kept under observation, preferably in bed, for a period of up to three hours. Ambulatory patients should not be permitted to operate a vehicle following injection. The usual precautions of reduced dosage should be observed when treating patients with impaired renal or hepatic function. The injectable form should not be given to patients in shock or comatose states. Reduced dosage (usually 25 to 50 mg) should be used for elderly or debilitated patients, and for children.

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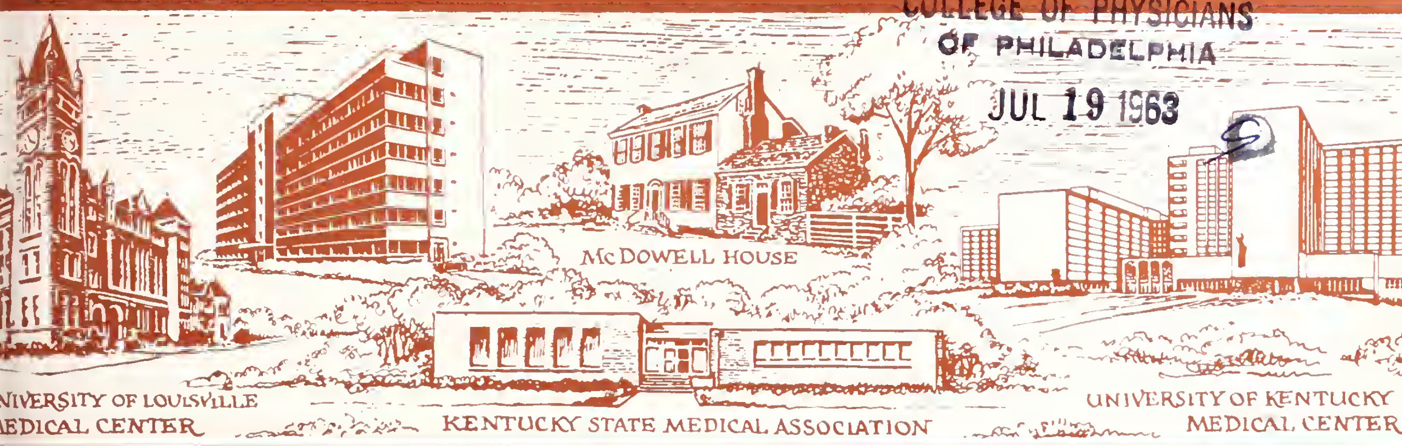

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KSMA Annual Meeting September 23-26, Lexington

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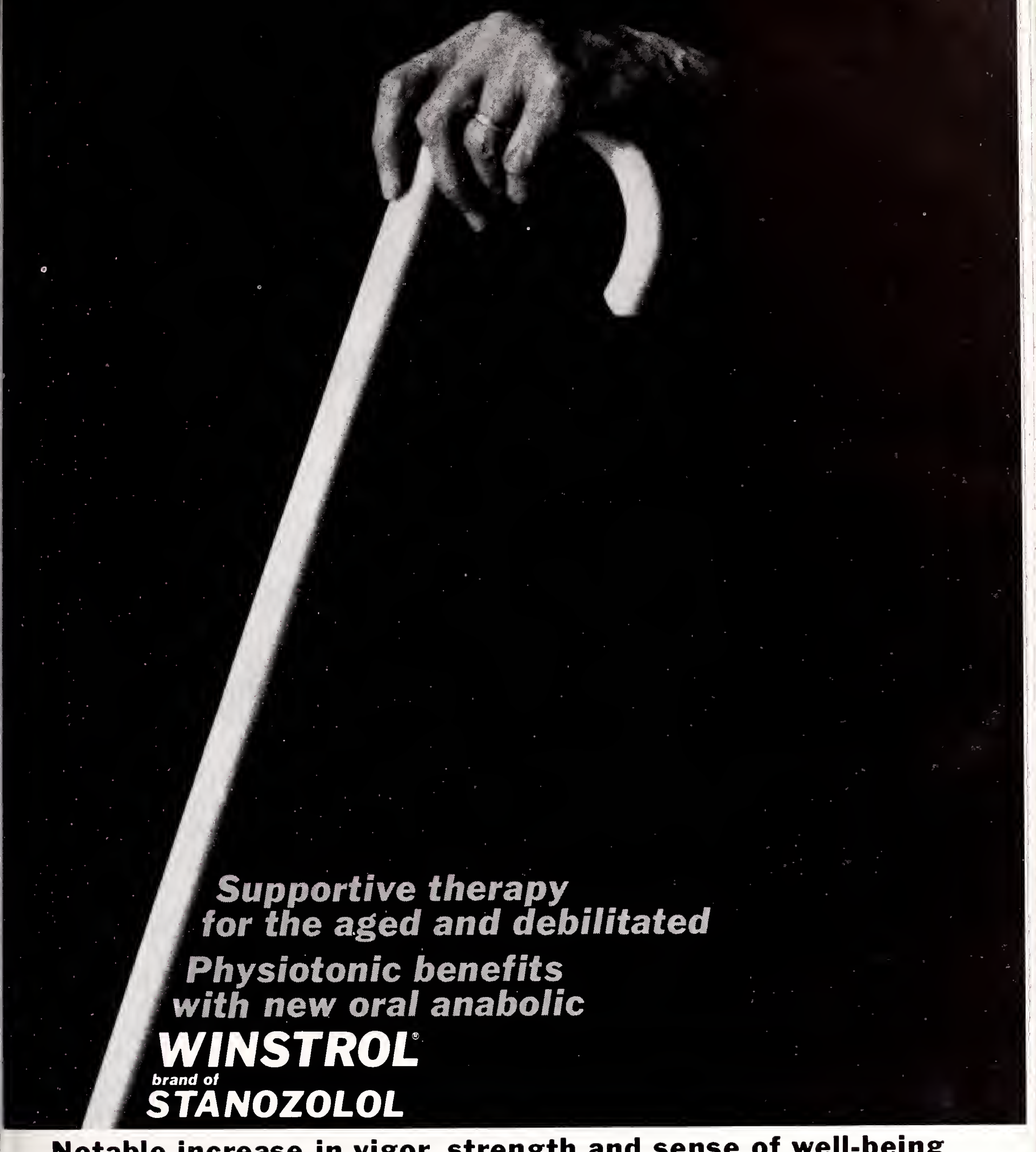

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Dosage: Usual adult dose, 1 tablet t.i.d. before or with meals; young women, 1 tablet b.i.d.; children (school age): up to 1 tablet t.i.d.; children (pre-school age): ½ tablet b.i.d. Available as scored tablets of 2 mg. in bottles of 100. For best results, administer with a high protein diet.

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MESSAGE FROM THE PRESIDENT

Aging

DURING the depression of the 1930's unemployment was so great that everyone was searching for some formula to prevent such a catastrophe repeating itself. The social planners were able to sell the idea that Government was the only group big enough to plan our country's affairs. A relatively small group said the people could not provide surpluses to tide over depression years. Compulsory Social Security tax was legislated to provide retirement sustenance for those in our lower income groups. Drawing the line between lower, middle, and upper income was an almost impossible task, so it was decided to tax salaries $3000.00 and under. That portion of the income over $3000.00 was not to be taxed.

The increase in the base to be taxed has been increased $600.00 on three occasions, and Representative Mills has just introduced a measure to increase it another $600.00 to $5400.00. Then, too, the amount taxed has been gradually increased from 1% on the employer and employee up to 3⅝%. Each increase has been brought about to cover added benefits.

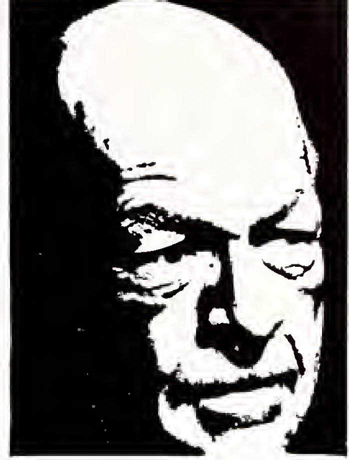
There are no provisions in any law telling people what to do with their time and energy after they retire. The death rate soon after retirement is considerably increased. Someone has said that people should retire not *from* something, but *to* something.

Retirement is good for the physically or mentally disabled. Many people after age 65 have leisure time for hobbies or a new interest. Theophratus wrote his "Characters of Men" when he was 90. Goethe completed "Faust" at 80 years. Pope John XXIII has influenced the world probably more than any man in the 20th Century and this was done from 78 to 82 years of age. Let us not further legislate how the Senior Citizen shall live.

David M. Cox

The new or early hypertensive patient

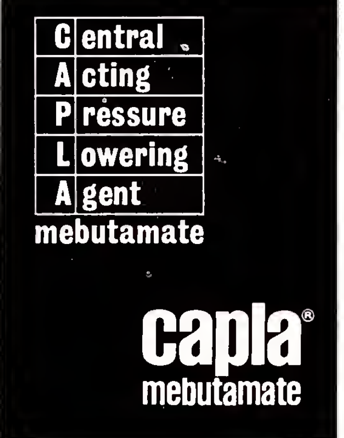
The middle-aged hypertensive woman



The geriatric hypertensive patient

The overweight hypertensive patient

When depression or peptic ulcer adds problems



Effective blood pressure regulation for the many faces of hypertension[1-5]

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Product Information: 'Capla' (mebutamate) is indicated for control of hypertension, either alone in mild cases, or in conjunction with diuretics or peripherally acting hypotensive agents in more severe cases. Its mild tranquilizing properties are often found an additional benefit to its antihypertensive action.

Drowsiness and occasional lightheadedness, usually transient, are often signs of dosage higher than necessary for therapeutic effect. There are no known contraindications to mebutamate.

Usual Dosage: One 300 mg. tablet 3 or 4 times daily, before meals and at bedtime. Dosage should be adjusted to individual requirements; for example, older patients may require lower dosage.

Composition: Each tablet contains mebutamate, 300 mg.

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References: 1. Corcoran, A. C., and Loyke, H. F.: J.A.M.A. *181*:1043, Sept. 22, 1962. 2. Costello, A. C.: M. Times *91*:53, Jan. 1963. 3. Holloman, J. L. S., Jr.: J. Nat. M. A. *54*:94, Jan. 1962. 4. Kheim, T., and Kountz, W. B.: New York J. Med. *62*:1596, May 15, 1962. 5. Leslie, C. H.: J. Am. Geriatrics Soc. *10*:85, Jan. 1962. 6/63 63WL3CK-12

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THE INSURANCE PAGE

Professional Services Index*

THE BLUE SHIELD Plans, in their Annual Business Meeting held in Chicago, April 16-18, 1961, directed the Committee on Professional Services to develop a Professional Services Index on which to base fee schedules for use in national accounts with employees located in more than one Plan area.

The Index was developed from existing and accepted fee schedules of all the Blue Shield Plans in this country. It is a composite of all of these schedules and is derived from indices which were found to be inherent in each. The Index has five sections of procedures, each of which remains independent from the other. The five sections refer to Medical, Surgical, Anesthesia, Radiological, and Pathological Procedures. In addition, standard coding and nomenclature has been developed which encompasses all of the commonly performed procedures in each section.

In brief, the method for deriving the Professional Services Index for each service consisted of the following successive steps:

1. The latest and best schedule for each Plan was obtained and the allowance for the studied services extracted.

2. The representative base for each type of professional service was selected and tested for reliability.

3. Mathematical relationships between the individual service and its base were obtained for each Plan. This relationship is referred to as a comparative factor.

4. The comparative factors thus developed were grouped into four categories: a. all Service Plans; b. all Indemnity Plans; c. all Plans having over 500,000 members; and d. Plans having schedules based upon relative value studies. The median comparative factor for each of the categories was then derived.

5. The median comparative factors derived in 4, above, were weighed to determine the composite Professional Services Index.

It is important to recognize that the professional services index is simply an index of relationships and does not in any sense constitute a prepaid medical care contract. The use of the Index in developing a prepaid medical care contract requires that the material herein be supplemented with whatever maximums, limitations, and professional policies are indicated to provide the necessary underwriting control. This is accomplished in two steps as follows:

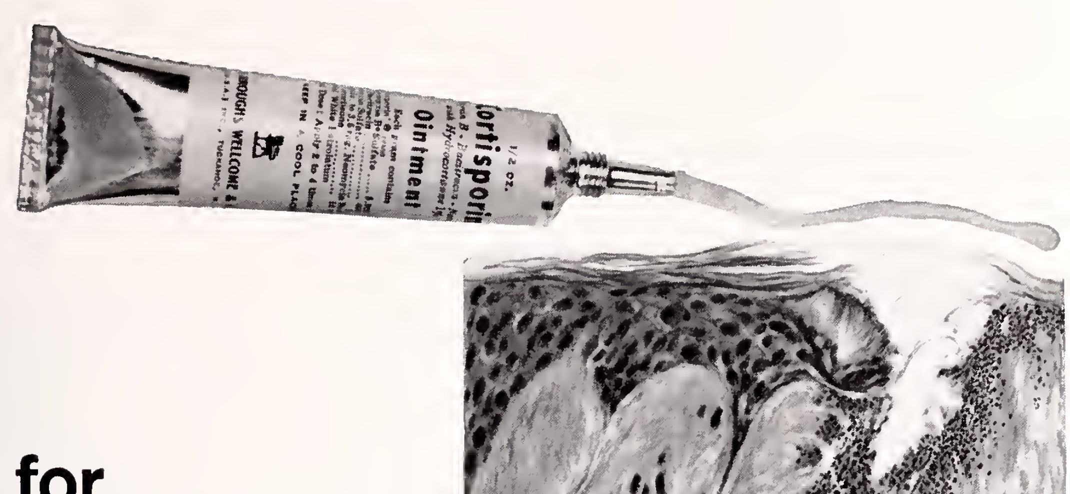
1. Mathematical conversion to schedules of the Blue Shield National Account Agreement which establishes unit values to covered procedures and relates them to any other procedure within a given section.

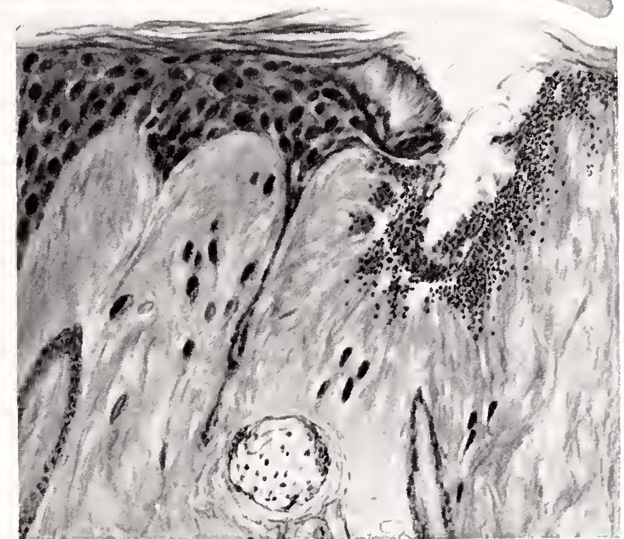
2. Application of a locally determined "conversion factor" to the unit values assigned. The "conversion factor" would be expected to vary from Plan to Plan to the same extent as fees for service vary from Plan area to Plan area.

It must be clearly understood that it is not the purpose of this Index to set fees for any individual, group or agency. It is a guide to the relationship between procedures, developed from the most practical medical economic information available anywhere, since it deals with the manner in which present day medical care costs are being paid for nearly 50 million Americans. Every Blue Shield Plan has contributed its representative share and every Plan has been equally influential in the results.

W. Vinson Pierce, M.D.

**This is the second of two articles dealing with the Professional Services Index, the first of which appeared in the June issue of The Journal.*





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Complete literature available on request from Professional Services Dept. PML.

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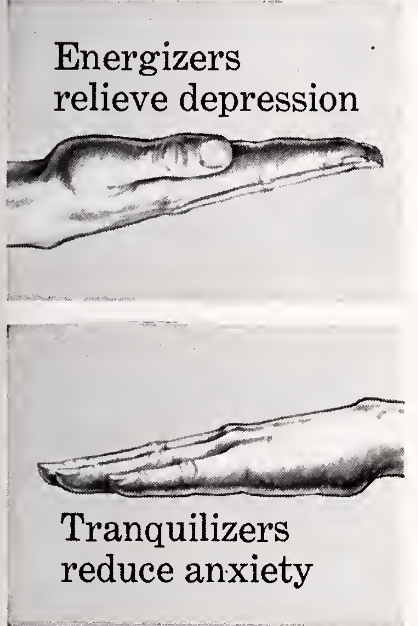

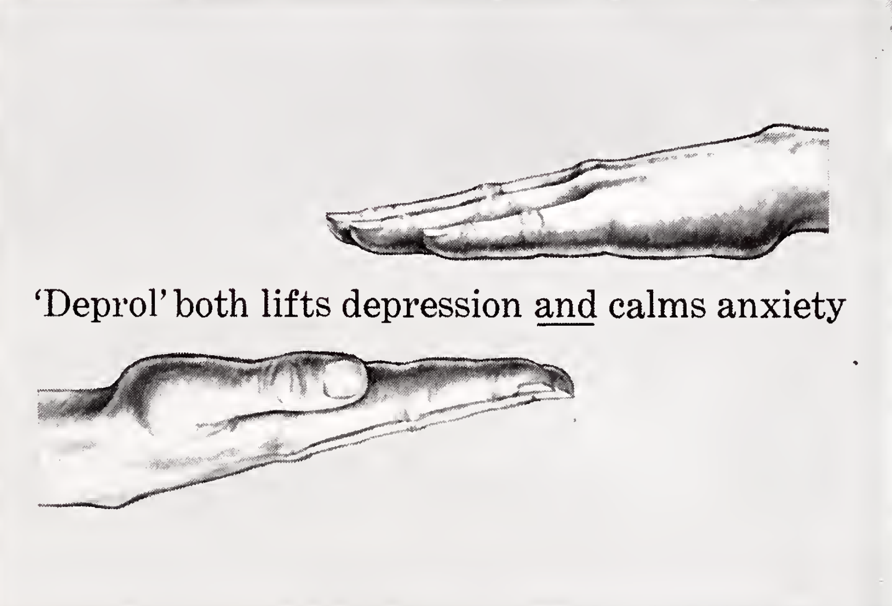

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IN THE BOOKS

SYNOPSIS OF NEUROLOGY: by Francis M. Forster, M.D.; published by the C. V. Mosby Company, St. Louis, Mo., 1962; pages, 223; price, $6.75.

This handy synopsis is a product of one of America's outstanding teachers of Clinical Neurology. Simply written, it clearly reviews the essentials of the neurologic history and the neurologic examination. A discussion of the common tests used in neurology follows with indications for their use. The descriptions of clinical neurologic entities are succinct and well defined, with the currently indicated therapy discussed.

Of particular value to the practitioner are the sections on headache and on epilepsy. In each of these the author points out the differential diagnosis and how each may be distinguished. Throughout each section are references to the new developments in the understanding of etiological factors involved in disease under discussion.

This book is designed to present neurology in a simplified manner to medical students and to serve as a handy review for those in general practice or specialty fields removed from clinical medicine. As such it will fulfill its purpose.

Frederick A. Horner, M.D.

SURGERY: by Richard Warren, M.D.; published by W. B. Saunders Company, Philadelphia, 1963; pages, 1,397; price, $19.50.

This book represents the newest contribution to the rapidly growing list of general surgery textbooks. The author expresses the desire to fill an educational vacuum created by the passing of Homans' *"Textbook of Surgery."* This is indeed an admirable and difficult task. While some recent entrants into this field have been specifically written for the student, the present volume attempts to fulfill the needs of student, resident and practicing surgeon. In some instances, the result is too much detail for the beginning student and not enough for the practicing surgeon.

The authorship of the textbook from one faculty of surgery, the Harvard surgical faculty, gives it an uniqueness not found in other major texts. This provides for a continuity of thought and a uniformity in presentation not present when major authors represent widely different surgical schools. The reader is provided with the evolution of thinking which has developed as a result of the constant association of the separate distinguished members.

The scope of the work makes it a true textbook of general surgery in that major sections deal with the subspecialties including Ophthalmology, Otolaryngology, Orthopedics, Genitourinary surgery, Gynecology, Pediatric surgery, Chest and Cardiovascular surgery. In many instances these subspecialties receive more emphasis than the usual material included in a general surgery curriculum. For example, it would seem that more than three pages could be devoted to the small bowel and that thyroiditis is rather inadequately covered in one-half of a page.

There is much about the format to be commended. The type is clear and legible with each page divided into two columns of print. The illustrations are particularly good and for the most part are line diagrams or drawings which clearly illustrate the principles discussed in the text. The bibliography is selected to give important historical reference as well as significant papers on each subject and does not attempt to include all available references.

In summary, this is an entirely new text which has many unique and desirable features. It will undoubtedly have wide acceptance among the surgical faculties of the country and will probably be most useful at the intern and resident level. Doctor Warren and his colleagues are to be commended on the successful completion of the tremendous work required to produce an entirely new textbook of Surgery.

William H. Marshall, M.D.

STRABISMUS (III)—Symposium of the New Orleans Academy of Ophthalmology": edited by George M. Haik, M.D.; published by C. V. Mosby Co., St. Louis; 369 pages; price, $18.

This erudite symposium pools much of the best current experience and analysis of seven leading students of strabismus in the U.S.A. Fourteen chapters highlight the pet subjects of each ophthalmologist. A generous give and take of edited round-table discussion adds 57 pages. These discussions are well sparked by penetrating questions from the floor, challenges between participants and sprightly humor, plus incisive neurology from David Cogan, M.D.

The push of Marshall Parks, M.D., for large (5 mm.) recession operations at the age of six months in congenital internal strabismus evoked considerable resistance from his senior colleagues. Forty-four pages of neuroanatomy of strabismus and 12 pages on the neurology of amblyopia from Michigan's John Henderson, M.D., constitute the longest, most detailed and most fundamental chapter. Other chapters are strongly clinical, and the surgical details of Ray Berke, M.D., and H. W. Brown, M.D., are clear and explicit.

The level of presentation throughout is aimed at the well grounded clinical ophthalmologist who shares with each of the authors a healthy restlessness over the still unsolved problem of etiology, diagnosis and management in this complex neuro-ophthalmic field.

Arthur H. Keeney, M.D.

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PUBLIC HEALTH PAGE

Benefit Liberalizations In Kentucky Medical Care Program*

Russell E. Teague, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

IT was announced by Governor Bert Combs at the sixteenth meeting of the Advisory Council for Medical Assistance that funds had become available to permit significant liberalizations in the benefit structure of the Kentucky Medical Care Program. This Program provides certain medical benefits to recipients of Medical Assistance for the Aged (Kerr-Mills) and recipients of Public Assistance. The action taken by the Council as a result of this development was consistent with the statement of philosophy adopted at one of its first meetings:

"*. . . Although necessary at this time because of financial considerations, it is recognized that . . . the Program stops short of covering medical care needed by persons under the Program, and of realizing the potential advantages of medical care for the protection and restoration of their health. Moreover, it is the intention of this Council to broaden the conditions for which payment for medical care will be provided at the earliest opportunity permitted by the availability of funds and experience under the Program.*"

The benefit revisions made possible by these additional funds became effective April 1, 1963, and are as follows:

Physician Services: The maximum number of payable home and office visits per recipient has been increased from twelve to eighteen visits per calendar year. These visits may be for preventive, diagnostic, therapeutic or rehabilitative services. Payment continues to be at the rate of $3.00 per office call and $5.00 per home call. The provision for granting extensions of visits in instances of unusual medical need is still in effect.

Hospital Services: The number of days per admission payable by the Program has been increased from six to ten days. Admissions payable continue to be those necessary for the treatment of an acute, emergency or life-endangering condition, including maternity care. Hospitals meeting minimum standards established by the Program are reimbursed on the basis of per diem cost. Hospitals not meeting these standards are paid by the Program at the rate of $7.50 per day.

Dental Services: In addition to the dental services previously available, the Program now covers one stannous fluoride treatment per year (consisting of dental prophylaxis and topical application) for children 17 years of age and under. Maximum payment for this service is $8.00. In addition, the annual dollar maximum per recipient has been removed.

Pharmacy Services: Seventeen new drugs are included in the revised edition of the Medical Care Drug List. Payment to participating pharmacies continues to be on the basis of wholesale cost plus professional fee.

Nursing Home Services: On January 1, 1963, nursing home benefits were included under the Program. Any Public Assistance or Medical Assistance for the Aged recipient whose medical condition requires skilled nursing care is eligible to receive these benefits. Payment to nursing homes participating in the Program varies according to the services available in the home.

In addition to these revisions in the benefit structure, several changes have been made in administrative procedures, some of which are designed to speed up the payment processing.

It is anticipated that additional funds and administrative revisions will continue to be forthcoming, resulting in a Medical Care Program of the highest quality which is satisfactory to all concerned—the provider-of-service, the recipient, and the taxpayer.

This article was prepared by S. H. Wester, M.P.H., Assistant Director of Medical Care, Kentucky State Department of Health, 275 East Main St., Frankfort, Ky.

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Mesenteric Infarction Without Organic Obstruction: A Report of Five Cases

BENJAMIN B. JACKSON, M.D., F.A.C.S.*
Louisville, Ky.

In approximately one out of five cases of mesenteric infarction, there is no evidence of mechanical occlusion. The agent responsible for gangrene is usually prolonged shock. Continuous epidural block offers the best chance of recovery.

FEW ENTITIES have provided as much frustration and caused as much discussion as mesenteric infarction without organic occlusion. The surgeon has incriminated the ineptness of the pathologist, and the pathologist is convinced that the surgeon is given to his usual rantings and that the embolus was dislodged in the transport of the corpse. However, even considering the frailties of both surgeon and pathologist, there is a group of cases with gangrenous changes in the gastrointestinal tract not associated with definite blockage of the arterial supply or venous drainage. A liberal glance at some two thousand cases of mesenteric arterial occlusion thus far recorded indicates that organic obstruction occurs in about 80% of the cases; whereas infarction with a patent mesenteric circulation is found in the remaining 20%. During the past three years I have been able to collect, from the Surgical Services of the Norton Memorial Infirmary, five cases of mesenteric infarction with no demonstrable mechanical obstruction. A survey of those five cases will be the foundation for the following comments.

The superior mesenteric artery supplies the entire intestine except the proximal segment of the duodenum and the distal half of the large intestine. Mechanical obstruction of the blood supply of the mid gut usually produces characteristic areas of ischemia. An obstruction at the mouth of the superior mesenteric artery usually causes gangrene from the ligament of Treitz to the mid transverse colon. Occlusion of the superior mesenteric artery at the level of

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the middle colic branch often precipitates necrosis from a point fifteen to twenty inches below the ligament of Treitz to the ascending colon.[4] Unless the middle colic artery is absent or hypoplastic, obstruction at the right colic branch seldom induces irreversible ischemia. In mesenteric infarction without evidence of mechanical obstruction, the ischemic changes may be diffuse, segmental, or spotty, but spotty gangrenous changes are perhaps more frequent. The area of ischemia may be greater than that supplied by the superior mesenteric artery and may overlap into the areas provided for by the coeliac axis or the inferior mesenteric artery.[11]

Etiology

The etiology of mesenteric infarction without evidence of occlusion has been appreciated only recently. The common denominator appears to be prolonged hypotension. All of these cases displayed persistent hypotension for at least twelve hours prior to the onset of abdominal pain. The hypotension may be related to infection, surgical trauma, massive hemorrhage, diabetic coma, or cardiac failure.[10] Shock in these cases was associated with myocardial failure. Apparently, the mesenteric circulation is sacrificed in behalf of the lungs, heart, and brain. In the dog, gangrene of the intestine will not occur until the blood pressure in the vasa recta is less than fifteen millimeters of mercury and blood flow is less than 10 cc. per minute per hundred grams of intestinal tissue for twelve consecutive hours.[12] Since restoration of blood flow in the dog six to eight hours following complete occlusion only advances ischemic changes, it is not feasible to restore the mesenteric circulation in the dog with the expectation of survival four to six hours following total deprivation of arterial supply.[14] These time intervals probably do not apply to man since cases are on record in which the obstructing agent was removed twenty-four hours after the onset of symptoms. Partially obstructing local obliterative disease, vasoconstrictor agents, or an ineffective collateral circulation only serve to expedite intestinal necrosis.[9]

Pathophysiology

The Law of LaPlace partially explains the pathological findings in this type of functional gangrene. Simply stated, when the blood pressure within the lumen of the vessel is less than the tension exerted by the smooth muscles in the walls of the arteries, the vessel collapses.[15] At laparotomy, the trunk of the superior mesenteric artery is pulsating but there is an interval in the vessel between the trunk and the vasa recta which is collapsed and empty. The terminal arcades and vasa recta are dilated and partially clotted. Histologically, the intestine reveals focal areas of necrosis, congestion of capillaries and arterioles, and submucosal hemorrhage; but the muscular and serosal layers are usually intact. Gangrene is most consistent with hemorrhagic infarction. No cases of anemic gangrene were found in these five cases at autopsy.

Other organs of the splanchnic bed may reveal evidence of infarction. It is not uncommon to find spotty hemorrhagic infarction of the liver, spleen, or kidney. In three of the five cases under discussion, there was simultaneous infarction of multiple organs of the splanchnic bed. Gangrene of the extremities has also been observed in association with mesenteric ischemia without evidence of organic occlusion.[1, 5, 6, 17]

Diagnosis

The diagnosis of this entity is not easily established. The first hint of mesenteric infarction is often found at the postmortem table. Only two of the five cases were correctly diagnosed antemortem. Laparotomy established the diagnosis in a third case but the preoperative diagnosis had been a bleeding, perforated duodenal ulcer. Most commonly the process occurs in aged females who have intractable congestive failure. In this series of five cases, four were females and one was male and all were associated with myocardial failure. Berger and Byrne found that twenty-one of twenty-three cases with hemorrhagic infarction without demonstrable occlusion were associated with a decompensated heart.[2]

The association of abdominal pain with congestive failure is well known. The interpretation of this pain is less clear. All gradations of symptoms and signs can occur in both organic and non-organic occlusion. In non-organic occlusion, the process is most often slow and occurs over days to weeks. In these five cases the shortest time prior to death was four days and

the longest was twenty-three days. Mesenteric infarction associated with aortic insufficiency, by contrast, may be fulminating.[5,8]

A continuous complaint of abdominal pain associated with persistent hypotension is important. Failure to relieve the pain by nasogastric suction or narcotics further enhances the possibility of intestinal ischemia. The patient frequently complains of tenesmus but the passage of a stool or gas does not relieve the symptoms. All of these cases demonstrated vomiting, restlessness, and exhaustion as part of their clinical picture. Melena was present in two cases and coffee ground vomitus was recorded in three.

Early the abdomen was flat but diffusely tender. No spasm was present but hyperactive, normal pitched peristalsis could be discerned in three of the five cases. The pulse was rapid and weak. The patient was cool and sweaty. Initially the patient was cool but temperature rose at the onset of peritonitis. Frequently, respiration was increased and thoracic suggesting generalized acidosis. The history and physical findings were almost identical with cases of organic occlusion except for the occurrence of refractory shock prior to the appearance of abdominal pain.

Simple x-ray procedures were of little value in diagnosis. Peritoneal tap yielded a dingy fluid in two cases. Presently, I believe there is no place for aortography in the diagnosis of this entity. The toxic effects of the contrast media hasten deterioration of marginal intestinal tissue.[18] Clinical suspicion, no doubt, is the best diagnostic tool.

Management

The management of these cases is confusing. It is not clear whether this is an agonal phenomenon and that attempts to dissuade gangrene are futile. Mortality in this series of five cases was 100%. In a combined series of forty additional cases, the mortality was 100%.[2, 6, 7, 11] However, this is a selected group of patients all of whom died. Perhaps there are others who got well without having their diagnosis confirmed. Until we have collected sufficient cases to clarify all shades of non-organic mesenteric ischemia, varied approaches will be used.

Not all cases of hypotension secondary to congestive failure, infection, recent bleeding, surgery, or diabetic coma will have non-organic occlusion nor will all cases of organic occlusion be free of heart disease, infection, hypovolemia and coma. Consequently, it behooves us in our present state of knowledge to maintain some degree of youthful enthusiasm. Correction of hypotension and a satisfactory urinary output are mandatory. If laparotomy appears essential for diagnosis, I would suggest a limited incision in the right lower quadrant. Careful inspection of the intestine will help determine whether the lesion is organic or functional. The terminal ileum is the most remote area in the mesenteric circulation and will bear the brunt of the ischemia. Failure to find pulsations in the vasa recta of the terminal ileum should focus attention on the proximal jejunum and if pulsations are present in the first fifteen or twenty inches of the jejunum, an organic obstruction is most likely present at the level of the middle colic artery. If ischemic changes are present from the ligament of Treitz to the mid transverse colon, and pulsations cannot be palpated in the root of the mesentery, the obstruction is most likely a thrombosis at the stoma of the superior mesenteric artery.

In non-organic obstruction, usually only the vasa recta and terminal arcades are involved. The trunk of the superior mesenteric artery is pulsatile but the interval between the terminal arcades and vasa recta and the proximal superior mesenteric artery is collapsed. Prominent changes in the mesentery in non-organic occlusion usually occur only over the distribution of the vasa recta. Often diffuse ischemic changes in the bowel extend from the ligament of Treitz to the rectum.

If an organic obstruction is present and the bowel is viable, an attempt should be made to remove it. Obviously if the bowel is non-viable, excision of all gangrenous tissue is required for survival. Certain evidence suggests that the wisest maneuver in non-organic mesenteric obstruction is to inject the root of the mesentery with dilute Xylocaine®. A periarterial dissection of the superior mesenteric artery has been suggested but is probably too traumatic to be successful in a gravely ill patient. Both procedures are designed to release the mesenteric circulation from noxious vasoconstrictor reflexes which impair peripheral mesenteric blood flow. Following closure of the laparotomy, continuous splanchnic or epidural blocks should be

given.[13, 16] The role of anticoagulants is not clear, and if they are used, splanchnic or epidural blocks may not be maintained with safety. Antibiotics, cardio-respiratory support, nasogastric suction, and correction of hypovolemia are mandatory. From Orr's experience, it would appear wise to reexplore the patient in twenty-four to forty-eight hours if improvement is constant but abdominal pain persists. He was able to resect a shorter segment of bowel following splanchnic block than would have been possible otherwise.[16] None of the cases in this series improved after developing abdominal pain and vomiting. However, none received anticoagulants or epidural blocks.

Summary and Conclusions

1. A survey of five cases of non-organic obstruction of the superior mesenteric artery is discussed.

2. The etiology of mesenteric infarction without evidence of definite obstruction appears to be refractory hypotension which is often secondary to intractable congestive failure, infection, diabetic coma, and hypovolemia.

3. In persistent hypotension of the splanchnic bed, mesenteric infarction can occur when the hydrostatic pressure in the intermediate arteries is less than the tension exerted by the circumferential muscle in the arteries.

4. Vasopressors, while they are transitorily helpful, only hasten mesenteric infarction.

5. The diagnosis is difficult. Abdominal pain, vomiting, restlessness, exhaustion and tenesmus associated with refractory hypotension suggests mesenteric ischemia. The physical signs are no different from a mechanical occlusion of the blood supply.

6. The treatment depends upon a correct diagnosis. A limited laparotomy may be helpful in establishing the diagnosis. In mesenteric infarction without evidence of organic obstruction epidural blocks are worthwhile. The blocks should be supplemented with antibiotics, cardio-respiratory support, nasogastric suction, and correction of hypovolemia. Reexploration is indicated in diffsue or spotty gangrene without evidence of organic occlusion, if the patient improves.

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Bacterial and Viral Meningitis In Infants and Children†

J. Neal Middelkamp, M.D.*
St. Louis, Mo.

Bacterial and viral meningitis, predominantly a disease of infants and children, can usually be differentiated by spinal fluid examination. Prognosis depends upon early diagnosis, identification of the etiological agent, and prompt institution of therapy.

MENINGITIS is still one of the most serious bacterial infections and a quick, accurate diagnosis with early institution of effective antimicrobial therapy is vital in reducing mortality and morbidity. The availability and widespread use of antimicrobial drugs have at times made it impossible to isolate the etiologic agent.

During the past ten years, it has been demonstrated that an increasing number of viral agents can cause meningitis. The diagnostic approach and therapeutic regimen have been affected by these developments. It would therefore be of interest to review the patients with meningitis who were treated at St. Louis Children's Hospital.

Diagnosis

Headache, fever, vomiting, lethargy, stiff back and neck, positive Brudzinski and Kernig, convulsions, and other neurological changes are recognized by most physicians as symptoms of meningitis. Unfortunately, very young infants may not develop the usual signs and symptoms of meningitis, and an altered respiratory rate may be the only evidence of their disease. It is important that physicians consider meningitis among other diseases during examination of any ill infant or child.

The physician can easily confirm his suspicion of meningitis by spinal fluid examination. Examination of spinal fluid should include a total and differential cell count, a stained smear for bacteria, bacterial and viral cultures, and quantitative analyses for sugar, protein and chloride content. The spinal fluid of patients with bacterial meningitis is usually milky or cloudy in appearance. The cell count is often over 1000 per cubic ml. and predominantly polymorphonuclear leukocytes. The spinal fluid sugar is decreased to 25 mg. per 100 ml. or less and the protein is usually above 80 mg. per 100 ml. Frequently, the causative bacteria can be seen on smear and positively identified by culture.

Bacterial Meningitis

During a 13-year period, from January 1947 through December 1959, 465 patients with bacterial meningitis were admitted to St. Louis Children's Hospital. About 25% of the patients with bacterial meningitis did not have an organism cultured from their spinal fluid (Fig. 1 and 2). The criteria used for including a patient in this group were that the patient had at least 500 cells per cubic ml. in his spinal fluid, the cells were predominantly polymorphonuclear leukocytes, and that the spinal fluid sugar was decreased. Nineteen patients had mixed meningitis, two different organisms being recovered from their spinal fluids. The bacteria cultured from the spinal fluid are listed in decreasing frequency from the top to bottom in both charts. Forty-eight per cent of these pa-

†*Presented at the KSMA 11th Trustee District Meeting at Richmond, Ky., on April 27, 1961.*

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tients were one year of age or younger. This is indeed striking since the remaining 52% comprised a 14-year age range of 1 to 15 years. Since over 50% of the patients were receiving antibiotics prior to admittance, the cultural isolation of the organism in 76% of the cases was considered fortunate.

Figure 1

BACTERIAL MENINGITIS

Organism	Patients No.	Patients %	< 1 Year of Age No.	< 1 Year of Age %	Previous Drug Therapy No.	Previous Drug Therapy %
Hemophilus Influenza	153	32.9	73	47.7	82	53.6
No Organism	110	23.7	47	42.7	76	69.1
Meningococcus	104	22.4	44	42.3	49	47.0
Pneumococcus	54	11.7	24	44.4	23	42.6
Mixed	19	4.0	15	78.9	6	31.5
Enterics	17	3.6	17	100.0	6	35.3
Streptococcus & Staphylococcus	8	1.7	4	50.0	3	37.5
Total	465		224	48.1	245	52.6

Hemophilus influenzae was the most common cause of bacterial meningitis among the infants and children of this series. Eighty-five per cent of these patients had a temperature over 38° C. on admittance, 81.7% had a stiff back or neck, and 6% had petechiae. Hemophilus influenzae was seen on smear of the spinal fluid in 77.1% of the cases but the coccobacillary, pleomorphic form of this organism was misinterpreted on smear in 11.7% of these cases. The high percentage of positive blood cultures, indicating an accompanying bacteremia, is in contrast to the low incidence of the isolation of the organism from the nose and throat. If Levinthal's medium or blood agar plate incubated in reduced 0_2 were used routinely, it is possible that these organisms would be isolated from nose and throat cultures more frequently.

In the group of patients from whom no organism was cultured from the spinal fluid, 85% had a temperature over 38° C., 80% had a stiff neck and 29% had petechiae. Bacteria seen on smear of the spinal fluid in this group were morphologically similar to meningococci in 18, pneumococci or streptococci in 13 and hemophilus influenzae in eight. Blood cultures were positive on six occasions for meningococci, twice for pneumococci, twice for Hemophilus influenzae and once each for staphylococci and pseudomonas. Since 70% of the patients in this group had received antibiotics, and the meningococcus, pneumococcus and streptococcus are sensitive to penicillin, this undoubtedly accounts for the inability to culture these organisms from the spinal fluid.

Fifty-four per cent of the patients with meningococcal meningitis had petechiae. Otherwise their clinical and laboratory findings were similar to those of Hemophilus influenzae patients.

Only one patient with pneumococcal meningitis had petechiae. The initial clinical and laboratory findings in the patients with pneumococcal meningitis were similar to the influenzal and meningococcal groups. Occasionally, the spinal fluid of patients with pneumococcal meningitis will be cloudy because of a myriad of organisms and relatively few polymorphonuclear leukocytes. Under these circumstances, an increase in pleocytosis with a decrease in organisms during the first several days of treatment indicates improvement in the patient's condition.

Meningitis caused by two organisms was seen primarily in young infants, and obviously indicates a severe infection. Hemophilus influenzae was one of the two organisms in 12 of the 19 cases. However, there was no definite statistical preponderance of any two organisms. The Hemophilus influenzae and meningococcus were isolated in four patients and in three patients the Hemophilus influenzae and pneumococcus were isolated. Frequently, the second organism was an enteric bacterium. In only two patients were both organisms seen on smear of the spinal fluid.

Figure 2

BACTERIAL MENINGITIS—LABORATORY DATA

	Cerebrospinal Fluid							
	Positive Smear		Culture & Smear Discrepancy		Blood Culture		Nose & Throat Cultures	
Organism	No.	%	No.	%	No.	%	No.	%
Hemophilus Influenza	118	77.1	18	11.7	49	38.2	8	9.2
No Organism	38	34.5			12	13.0		
Meningococcus	76	73.0	6	5.8	24	25.0	17	25.0
Pneumococcus	40	74.0	3	5.5	7	15.5	13	38.2
Mixed	10	52.0	8	42.1	0		0	
Enterics	8	47.0	0		8	50.0	4	100.0
Streptococcus & Staphylococcus	4	50.0	2	25.0	1	12.5	0	

% Based on Actual Number of Cultures Done

E. coli, salmonella, proteus, pseudomonas and Alkaligenes fecalis comprised the enteric organisms producing meningitis in 17 patients, all under three months of age. The thick, creamy character of the spinal fluid in some of the infants suggested that the infection was of longer duration than indicated by the history.

Streptococcal and staphylococcal meningitis are indeed rare today as compared to the preantibiotic era.

Treatment

All of the patients from 1947-1954 were treated with parenteral penicillin, streptomycin, and sulfonamides and multiple injections of intrathecal penicillin and streptomycin. Since 1954, most patients also received chloramphenicol parenterally in addition to penicillin, streptomycin and sulfonamides. With the present regimen, when the spinal fluid suggests bacterial meningitis, the patient usually receives an initial injection of penicillin and streptomycin intrathecally. After the causative bacterium has been isolated and identified, antibiotic sensitivity tests are done, and the drugs considered best for the treatment of this specific infection are maintained and the other drugs are discontinued. The results attained by this therapy are given in Fig. 3. It is obvious that patients with mixed meningitis or a meningitis caused by enteric organisms have a very poor prognosis. The mortality rate and sequelae are not as low as one would like to see. This probably reflects undue delay in diagnosis and institution of therapy.

Viral Meningitis

In contrast to bacterial meningitis, the spinal fluid in viral meningitis usually is clear, with 50-500 cells per cubic ml. Mononuclear cells are predominant but early in the course of viral meningitis, there may be 50% polymorphonuclear leukocytes. The spinal fluid protein is between 50 and 80 mg./100 ml. and the sugar and chloride contents are normal. Certain viruses can be isolated from the spinal fluid with the aid of tissue culture. Smears and cultures on artifical media are always negative.

Until recent years, the etiologic agent in viral meningitis was rarely identified. Prior to 1953, the serologic method was used for the identification of viruses because animal inoculation for viral isolation and identification was difficult and laborious. It is therefore not surprising that Adair[1] was able to determine the etiology of viral meningitis in only 25% of his patients. Following the development and use of tissue culture, Davis and Melnick[2] were able to establish the viral etiology in 70% of their patients.

Recently, our laboratory reported the identification of 83% of the viral agents producing meningitis in infants and children.[3] The viral etiology was determined by isolation of the virus in conjunction with the demonstration of at least a four-fold rise in serum neutralizing antibody to this virus. Only 10% of these patients were under one year of age as compared to 48% of the patients with bacterial meningitis. Unfortunately, there was no characteristic clinical picture produced by any one of these viruses that would indicate the specific viral etiology. In the past, paralysis was thought to be associated with poliovirus infection only, but today other viruses are known to be paralytogenic.[4, 5]

Figure 3

BACTERIAL MENINGITIS—RESULTS OF THERAPY

Organism	Patients No.	Recovery Without Residual No.	%	Sequelae No.	%	Mortality No.	%
Hemophilus Influenza	153	106	69.2	25	16.3	22	14.3
No Organism	110	92	83.6	12	10.9	6	5.4
Meningococcus	104	83	79.8	12	11.5	9	8.6
Pneumococcus	54	33	61.1	14	25.9	7	12.9
Mixed	19	5	26.4	6	31.5	8	42.1
Enterics	17	1	5.7	3	18.2	13	76.2
Streptococcus & Staphylococcus	8	3	37.5	2	25.0	3	37.5
Total	465	323	69.4	74	15.9	68	14.6

In our series, 31 patients were studied and 16 were found to have poliomyelitis due to poliovirus Type 1. Fifteen of the 16 had paralytic disease and five had received Salk vaccine. All of the patients who had received Salk vaccine had evidence of paralysis on admittance. Two had received three injections, two had two injections, and one received only one injection. As was expected, poliovirus was isolated from the throat and stool specimens of these patients, but not from their spinal fluid. One patient expired in the acute phase. Twelve months later, 10 of 13 patients re-examined were found to have residual paralysis.

ECHO virus Type 9 was isolated from seven patients with meningitis. No muscle paralysis or weakness was elicited in any of these patients, though residual paralysis following infection with this virus has been reported.[4] In five of these seven patients, the virus was isolated from the spinal fluid as well as from the throat and stool specimens.

One 13-month-old child with Coxsackie B_3 meningoencephalitis exhibited weakness of both lower extremities on admittance but improved rapidly, and no residual weakness was noted on discharge.

Mumps meningoencephalitis occured in two patients with no paralysis or weakness. These patients did not have clinical parotitis. Both Coxsackie and mumps viruses were isolated from throat and stool specimens. Their isolation from spinal fluid has been reported by others.

A viral etiology was established in 26 of the 31 patients studied. No viral etiology was established in the five remaining patients whose spinal fluid findings were consistent with a viral meningitis. These five patients did not demonstrate any weakness or paralysis.

To date, there are no specific antiviral agents available for therapy. Vaccines for poliomyelitis have been developed which resulted in a definite decrease in the incidence of this disease. At present, active research is being conducted in developing other viral vaccines, and many chemical compounds are being studied for antiviral properties. It is possible that antiviral biotics may be available within the next few years. Then it will be as important to differentiate a Coxsackie from an ECHO meningitis as it is to determine if the meningococcus or an E. coli is the agent in bacterial meningitis today.

Summary

Certain points deserve re-emphasis when dealing with meningitis in infants and children. 1) Early diagnosis of this disease is of paramount importance. 2) In the young infant the classical signs and symptoms of meningitis may be absent. Since there are many good antibacterial drugs available and all bacterial infections are potentially curable, the early diagnosis of bacterial meningitis is especially important to prevent residual damage. 3) A good clinical diagnostic laboratory is essential in establishing the specific etiology of meningitis. Antibiotic sensitivity tests help in choosing the best therapeutic agents. 4) An increasing number of viruses have been shown to cause meningitis. The physician should become acquainted with these viruses and the diseases they produce, since new vaccines are being developed for the prevention of infections with these agents. Specific antiviral agents may become available before the end of this decade.

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A Post-Hospital Study of Kentucky Addicts— A Preliminary Report†

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Follow-up data suggest an unexpectedly high abstinence rate among rural addicts. Reasons may include improved medical practice and suppression of illegal sources, making narcotics difficult to obtain.

IN MAY, 1935, the U. S. Public Health Service Hospital in Lexington, Kentucky, was established for the treatment of narcotics addicts. Since that date, there have been about 70,000 admissions to the hospital, of which approximately 60% were first admissions. Hospital treatment includes withdrawal of narcotics, medical and surgical treatment, psychotherapy to the extent that staff limitations and patients' readiness for it permit, vocational training, and a drug-free therapeutic environment in which patients' attitudes and personalities may be modified. For a detailed description of the hospital program, see James V. Lowry, M.D., "Hospital Treatment of the Narcotic Addict," *Federal Probation,* December 1956, pp 42-51.

The hospital staff has long advocated follow-up services to patients in their communities after discharge as essential to maintain the benefits of hospitalization and prevent relapse, but with the exception of those prisoners and probationers who are discharged under the supervision of Federal Probation Officers, few patients have received this help.

Earlier Studies

A question is frequently raised as to the percentage of patients who relapse to drug use after discharge from the hospital. While an answer to this question would not be a measure of the effectiveness of hospital treatment, which would require a control group of non-treated addicts, it has interest in its own right, and would throw some light on the natural history of addiction. The first attempt to answer this question was based on the 4,766 male patients discharged from the hospital from January 1, 1936, to December 31, 1940. Data were available from the records of readmitted patients, from Federal Bureau of Investigation reports of subsequent arrests, from reports of Probation Officers on the patients under their supervision, and from letters of inquiry sent periodically to those former patients no longer under supervision, or to their relatives. Among its findings, this study reported, for "Present Addiction Status" of the former patients, that 7% were dead, 14% abstinent, 40% relapsed, and

†*The study is supported by a National Institutes of Health Grant (M-4014) for a two-year period which began on Sept. 1, 1960. It is being conducted at the U.S. Public Health Service Hospital, Lexington, Ky., by the author and Mr. William F. Owsley. Robert Straus, Ph.D., chairman of the department of behavioral science of the University of Ky. Medical Center, is co-principal investigator. This report is a revised form of a paper read before the Kentucky Psychiatric Association in Louisville, Ky., on September 21, 1961.*

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40% were classed as unknown (percentages rounded).[1]

A more recent study[2] followed 1,912 patients who had been discharged from the Lexington hospital between July 17, 1952, and December 31, 1955, after completing the withdrawal period. All subjects were residents of New York City. The data were obtained from official records and, in a large but unspecified proportion of cases, from interviews with the former patients and/or their relatives. Of the 1,881 patients on whom data were secured, 90.1% were judged to be readdicted, 6.6% abstinent, and 3.3% used narcotics irregularly, or their addiction status could not be determined. Other follow-up studies, of addicts treated elsewhere, also suggest high relapse rates.[3]

Present Study

The present study is similar to the preceding ones, though smaller in scale, aimed at a different type of population, and including one important methodological improvement, to make the determination of addiction status objective and reliable. It should be emphasized that the present study is only well started, and a report on it would not normally be made so early. The officers of the Kentucky Psychiatric Association, however, felt that the study would be of interest to its membership, and that a preliminary report would be useful.

The general purpose of the study is to determine, for a sample of the addicts who have been hospitalized from Kentucky, their current addiction status, or their addiction status at time of death, and their history of drug use, in the hope of learning something about the factors which are associated with relapse to drug use or continued abstinence from such use. In the design of the study this purpose, of course, had to be broken down into a number of specific hypotheses. Some of the major ones will be pointed out as they become pertinent in the following discussion.

Narcotic drug addiction today is primarily a problem of a few metropolitan areas, but there are aspects of the addiction problem which can be studied in Kentucky as well as, or better than, they could be studied in metropolitan areas.

In the first place, hundreds of patients are admitted each year from the cities and small towns of the Southern states. The Kentucky patients, who come from both rural and urban areas, are representative of a broad range of addicts. Another point is that most follow-up studies have focussed on metropolitan areas, and none have compared rural with urban addicts. It is obviously a possibility that important differences may exist between these groups.

As one example, almost all metropolitan addicts were introduced to drugs by friends, and their main, or only, source of drugs has been the illegal heroin market. When they leave the hospital and return home, they return to areas where narcotics are easily available to them, and where their friends and acquaintances are likely to encourage them to relapse, or at least make relapse easy for them. Among Kentucky patients, and among patients from other states, on the other hand, there are many cases in which the original drug use was in the course of medical treatment, and where perhaps all narcotics were secured from legal sources. The patient may have known no other addicts, or very few of them. When he returns home, there may be no easy way for him to obtain drugs, and no social pressures on him to use drugs again.

Some of our major hypotheses are identified by rephrasing this paragraph. There will be some differences in relapse rates between those whose drugs came from legal sources and those whose drugs came from illegal sources; between those who know few, or no, other addicts and those whose environment includes many addicts; between those whose self-concept is of an ill person taking medicine and those whose self-concept is of a "cat" seeking kicks.

Subjects and Methods

As first step, individuals who form the population of this study were identified: addicts, whose address on first admission was within Kentucky, admitted between May, 1935, and December, 1959. One thousand sixty-three individuals met the criteria. Of these, 50 were Negro, all the rest white. It was evident that there were too few Negroes for any statistical comparisons, so the study was restricted to whites only. It will actually be based on a sample, consisting of 285 individuals, in 37 counties of the state.

The next major step was to abstract the hospital records of the 285 subjects, a procedure only recently completed. Certain face sheet in-

formation is available on all cases, but there is much variation in the remainder of the records. In some there is very little information, in others more than can be used statistically, though it should still be useful. In all cases, of course, every possible lead that will help locate the patient was recorded.

Interview Schedules

While this abstracting was going on, interview schedules were designed and tested, first on Kentucky patients who happened to be in the hospital, or who were admitted after the study began, and then by a pilot field trip. Continued revisions were made and the number of items reduced to what was found to be practical in most interviews. In the first field trip, and one later one, two interviewers worked together, to standardize their procedures and ensure that both would get the same minimum data. All future trips will be made by single interviewers.

The confidential nature of the subject of the study was a major concern before the first field trip. Most subjects were voluntary patients, and the law which authorizes the hospital to treat them specifically forbids releasing any information about their hospitalization to anyone. While this law does not apply to those patients who were prisoners or probationers, the ethical limitations are identical. A basic operating rule was established that no injury to an ex-patient, by divulging the fact of his past addiction, would be risked, even if this meant the loss of data in so many cases that the statistical design would be threatened, and the findings reduced to dubious value.

Protection of Subjects

While this concern persists for metropolitan subjects, it was quickly dispelled for the rural counties. When the interviewer asks about addicts in the county, subjects and other informants tell him not only about the subjects, but also about other addicts who have never been patients in the hospital. In rural Kentucky, if you are an addict, this is not confidential information; the whole town knows about it. And they do not hesitate to talk about it, at least to those who, like our interviewers, have a legitimate interest in the subject.

By the end of the summer, field trips had been made to fifteen counties in the sample, these counties accounting for 91, or almost one-half, of the non-metropolitan subjects. Of these 91 subjects, 26 were located and interviewed. Forty-seven were reported as dead, and the death of all but two of these has been verified. The remaining 18 had moved, some to other parts of the state and some outside the state, but most of these into neighboring states. Interviewers should be able to interview most of these, if time and money permit.

There had been a question, of course, how cooperative and helpful the subjects would be when they were located. Once more, the reality was pleasantly different from the fears. So far, no subject has flatly refused to talk. Most interviews range between 45 minutes and 90 minutes. One subject was unwilling to go into any detail, but did answer the major questions. Another was unwilling to talk more than about 15 minutes, because her children were at home, and she did not want them to overhear anything which might reveal her past drug use.

Cooperation

Of those who were abstinent from drugs, most seemed pleased to see the interviewer, were quite proud of their abstinence, and they were willing or even insistent that their wives and children and doctors be interviewed for verification of their statement that they were abstinent. Of those who were using narcotics at the time of the interview, all except one admitted this use, and tended to talk freely about the illnesses or symptoms which, at least in their opinion, made this use necessary. With only a few exceptions, subjects have been willing for the interviewer to talk to their physicians about them.

While it is highly probable that some patients have given false information, or omitted facts it would be desirable to have, there is good evidence that on the major points on which the study focusses, almost all subjects are telling most of the truth.

This evidence exists in two major forms, information from other sources, and urine tests. First, in most cases statements have been obtained from other informants. As an example, take the first ex-patient located, though the confirming evidence in his case is somewhat

stronger than the average. In the County Health Department, two informants told the interviewer that Mr. Jones had been abstinent from narcotics for eighteen years, ever since his return to the community. One of these informants was a member of Jones' Sunday School class, and mentioned that he had not missed church or Sunday School for over 300 Sundays. The Chief of Police also spontaneously mentioned Jones as one addict who had definitely quit drug use. Another subject in the same town, a man who freely admitted his own current use of narcotics described Jones as not having used any drugs at all since his return home. The brother of another subject also mentioned him as "a completely changed man," who used neither drugs nor alcohol. Jones' mother was present during the interview with him, and took the opportunity offered when he left the room for a few minutes to say that every word he had told us about his excellent adjustment was true.

In 24 of the 26 cases where the subject was interviewed, there are from one to four or five statements from other informants. In 14 of these cases, one of these statements is from the family physician, or another physician who was familiar enough with the subject to mention him spontaneously. In only 2 cases are there no statements from other persons. One of these was a physician, and the rule was applied that the interviewer should not risk reminding anyone of an episode he seemed to have lived down. Another was a woman who admitted her current drug use. The only useful additional information would be from her physician, who was away on vacation. A letter was written to him, with her consent, but no reply has been received.

Urine Examination

The second kind of evidence against which the subject's statement can be checked is his urine sample, which is tested for narcotics and barbiturates by the Addiction Research Center. Several points are worth making about the urine samples: 1. So far, 25 of the 26 subjects seen have given specimens. The 26th subject was willing to give one, but the interviewer had forgotten the specimen bottle, and the subject died before he could be located again.

2. The specimen is requested at the end of the interview, with an explanation that it will reveal any recent use of narcotics or barbiturates. If the patient had falsely denied current drug use earlier in the interview, one might expect some reluctance to furnish the specimen, but reluctance in such circumstances has not been noted. It has appeared only when the subject has admitted drug use, and then seems to reflect a fear that the sample may be used as evidence against the subject.

3. The urine test is direct evidence only for current drug use. In any individual case, it in no way confirms a claim that the subject has been abstinent for, say, ten years. If, however, the present pattern continues, that subjects claim periods of abstinence, and then test negative, the test results will be indirect evidence for the periods claimed. It would be difficult to believe that all the subjects were lying, and had happened to quit drug use only a short time before the unscheduled interview.

Findings To Date

It is too early to report any results since the number of cases is still small, and these cases do not constitute a random sample of the population. Almost one-half of non-metropolitan cases, however, have been completed, so the final data for these cases probably will not be materially different.

The findings to date suggest that about half of the study subjects are deceased. About one-third of these died from non-natural causes—by accident, murder, suicide. The average age at death was about 50, but the average age at hospitalization for the group was in the late 30's or early 40's, so their life expectancy probably was much over 50. Life expectancy tables for Kentuckians over the 1935-59 period will be constructed in order to determine the difference of the study group from the average, but present findings suggest that the age at death of the study group will be considerably lower than the average.

It will be difficult to classify the addiction status of some of the deceased patients because the information needed refers to past periods, and the informants who could furnish it are frequently no longer available. The proportion in the "unknown" category probably will be larger for this group than for the rest of the study group.

A total of 26 subjects were found and interviewed. Eleven of them can be classified as now

abstinent from narcotics, and as not using either alcohol or barbiturates as a substitute. One of these is a man who probably never was a narcotic addict but an alcoholic whose family falsely claimed he was addicted to get him into the hospital. The other ten who are abstinent consist of six women and four men. Four of the ten admit to periods of narcotics use after their last discharge from Lexington. Their claimed periods of abstinence range from two to eighteen years, with the average between seven and eight years.

Seven more, all male, are abstinent from narcotics now, and claim periods of abstinence from a few months to twelve years, for an average of almost four years, but all are severe alcoholics, or have been for most of the time of abstinence. One of these, a man who had been abstinent for five months when interviewed, later relapsed to irregular use of morphine and to regular use of barbiturates, and was readmitted to the hospital.

The remaining eight, five men and three women, are currently addicted to narcotics. One of these had denied drug use. The other seven all claim that their narcotics are prescribed by physicians for illnesses, and this source of drugs has been verified for three of them.

High Rate of Abstinence

About a fifth of the subjects have moved from the places where they originally used narcotics. In some of these cases, one major motive for the move seems to have been to get away from the source of narcotics. If the fragmentary information obtained on these subjects turns out to be correct, their rate of abstinence may be even higher than among the subjects we have so far located.

From the findings to date, it appears the abstinence rate will be appreciably higher than has been reported in any previous study of this type. It is a higher rate than experienced workers in the field of addiction would have dared to predict.

All the data will be searched for factors associated with this apparently high rate of abstinence. There is, for example, a suggestion that the rate of abstinence may be much higher for women than for men. Other such relationships may be found. It will not be possible to explain abstinence in terms of personality characteristics or dynamics, because the interview is not designed to get such data.

The Availability Factor

One factor exists in so many of the cases that its importance seems already evident. While this must remain a matter of opinion, there are strong indications that some of the abstinent subjects would be using narcotics now if narcotics were available. In other cases, even though the subjects might now be able to abstain even if narcotics were easily obtained, it seems highly probable that the unavailability of drugs was important in the first year or two of abstinence.

This relative unavailability of narcotics, according to the information obtained, arises in several ways. In the first place, there is agreement that illegal markets do not exist in the communities visited. The second reason given is that physicians are more careful with narcotics than they were twenty or thirty years ago, or perhaps need to use narcotics much less because specific remedies are now available.

Finally, in a few cases subjects state that they deliberately left areas where they could get narcotics and moved to an area where they would not know how to obtain drugs.

This factor of unavailability may go far in explaining the high rate of abstinence in this group, in contrast to previous follow-up studies which were conducted in, or included, the large metropolitan areas where the illegal narcotics market has never been completely abolished.

To date, there have been no cases in which a subject's abstinence can be attributed to psychiatric treatment after his return home. The reason was readily determined to be that the communities had no psychiatrists in practice. The potential value of such treatment is suggested by one case in which a woman's abstinence seems attributable, in large part, to supportive therapy from her family physician, over a period of years.

Summary

In summary, a start has been made on a follow-up study of treated narcotic addicts. It is small in scale but shows promise of contributing some new knowledge about addiction. Specifically, it should add to our knowledge of the

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Hormonal Aspects of Peptic Ulcer†

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The relationship between peptic ulcer and the hormone producing tissues under normal and abnormal conditions is reviewed.

IN THE PAST decade there has been much interest in the relationship of peptic ulcer to multiple endocrine abnormalities. This is certainly understandable, as the etiology and pathogenesis of ulcer remain obscure. Since ulcer stands alone in its frequency, morbidity and occurrence in otherwise apparently healthy young people, the importance of this work is much more than academic.

Ulcer incidence is actually difficult to determine. Asymptomatic lesions or scars are seen on X-rays taken for other purposes and, in many instances, the history may be atypical. Ivy[1] suggests a figure of 5-10% of the population, but this is admittedly a very gross estimate of the problem.

Treatment has changed remarkably little in a ten- or even a fifty-year period. Diet, antacids, and antispasmodics remain basic, and although there is much discussion on which diet, antacid, or antispasmodic is most satisfactory, there is doubt of the advantage of a particular regime as long as basic principles of therapy are maintained.

The serious complications of ulcer (perforation, obstruction, and hemorrhage) have probably benefited most from modern methods. These medical failures are often referred to our surgical colleagues who, although of great help in relieving or repairing these complications, have met with limited success in curing the disease. The many techniques devised, although frequently on sound physiological bases, make it clear that the ideal operation has not been devised.

A basic concept of ulcer etiology includes the fact that gastric secretion is markedly increased. Since many data suggest an alteration of this phenomenon in diseases of endocrine glands, it is the purpose of this paper to review this subject in an attempt to clarify a mechanism of the peptic ulcer syndrome. In a few cases, diagnosis and treatment will also be aided by this knowledge.

Adrenal and Pituitary Glands

Since steroids were first used clinically, some relation to ulcer has been suspected. In 1950, Gray[2-4] first postulated a hormonal phase of gastric secretion transmitted from the higher centers in the brain through the posterior hypothalamus to the adrenal cortex where production of steroids might result in direct control of gastric acid and pepsin secretion. This pathway seemed independent of the gastric antrum and the well-known neural pathway involving the anterior hypothalamus, vagal centers, and vagus nerve. He thereby suggested that the gastric and peptic glands may be integrated into the neuroendocrine system partially controlled by the hypothalamus, pituitary, and adrenal glands.

Certainly this was an attractive theory and already in agreement with several known facts. Grawitz[5] in 1907 had seen a prevalence of achylia or achlorhydria in patients with Addison's disease and this had been confirmed.[6]

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Also, chronic or acute physical or emotional stress have long been suspect in the etiology of ulcer, making the neurohormone theory very acceptable. For example, Curling's ulcer, associated with severe burns, or Cushing's ulcer, with central nervous system lesions, can be cited as acute stress ulcers. More recently, stress ulcers have been suggested following cardiac surgery and myocardial infarction.[7, 8]

Measurement of Gastric Activity

In an attempt to investigate this hypothesis, measurement of gastric activity was done under various experimental and clinical situations. Gastric juice is difficult to study because the nasal gastric tube is difficult for the patient and accuracy of collection is always questionable. Thus, Gray and his group measured pepsin in the urine as a reflection of gastric activity.[2-4]

Pepsin, produced by the chief cells of the stomach mucosa, is mostly excreted into the lumen where it is available for digestion of protein. A small amount, however, is directly absorbed into the blood stream and carried to the kidney where it appears in the urine as uropepsin. The ratio of gastric to uropepsin was considered rather constant. As expected, duodenal ulcer patients excreted more than 8000 units in a 24-hour urine specimen compared to 3500 units in normal subjects. When adrenocorticotropic hormone was given in high doses for some weeks, uropepsin values approximated or exceeded duodenal ulcer values. It was soon noted, however, that response varied considerably depending upon individual susceptibility and the dose and duration of hormone administered.

Findings Extended

Although vagotomy and antral resection do not appear to alter this response, it was shown in Heidenhain pouch dogs and in vagally denervated and antrectomized animals that gastric acid and pepsin repsonse to the adrenal steroids were more consistent. For example, gastric secretion increased 300-400% following the oral administration of prednisone to dogs for ten days.[9]

Gray et al[4] extended these findings to many aspects of the problem. They studied situations of acute and chronic stress including medical students at exam time, athletes before and after events, and specific endocrine diseases. In a series of 363 patients with untreated Addison's disease, chronic peptic ulcer was found in only three instances; but seven treated patients developed ulcer when on small daily doses of cortisone. It was found that gastric secretion is diminished in panhypopituitarism and myxedema and apparently returns to normal with corticotropin and thyroid replacement therapy. Uropepsin and gastric secretion are increased in patients with Cushing's disease, although ulcer is surprisingly uncommon. Kyle[10] reported a return of gastric acid to normal following adrenalectomy.

Many more studies have been presented to substantiate claims of the proponents of hormonal gastric secretion and ulcer. These findings have been of real value to the clinician because new or reactivated ulcer is a real threat to patients treated with ACTH or cortisone. An incidence of 5-7% or more in large series of patients receiving adrenal steroids attests to the need for careful evaluation of gastrointestinal complaints and prophylactic measures to lessen the likelihood of ulcer occurrence in many cases. This is especially true because ulcer incidence seems increased in rheumatoid arthritis, emphysema and other conditions where steroid treatment is sometimes used.

Mechanism of Production Unclear

Actually, the mechanism of ulcer production during steroid administration is not clear and does not seem related to their major metabolic effects.[11] Patients with peptic ulcer do not show elevated urinary or blood levels of hydroxycorticosteroids. Increased levels are evident during and after surgery or with acute burns, but this is an example of an acute stress mechanism where other factors, too, are involved.

Attempts have been made to give small amounts of corticotropin to ulcer patients to determine if the adrenal glands of these persons react differently to "minimal" stress. It has been found that there is no difference in ACTH response among ulcer and normal persons.

Both the method of study and humoral theory of ulcer have been attacked by many authors. Hirschowitz,[12] for example, was unable to correlate gastric, blood and uropepsin values. Jude and Harris[13] although confirming

that steroids cause slow augmentation of acid and pepsin values, did not find that uropepsin necessarily mirrors gastric mucosal activity. Dragstedt and his group[14] do not accept the humoral theory of ulcer production and found no effect of ACTH, cortisone, or insulin on gastric secretion.

Adrenal Steroids Increase Acidity

Recently, Card[15] from England demonstrated in humans that adrenal steroids significantly increase gastric acidity and the gastric acid response to maximal histamine stimulation. It was thus postulated that the adrenal steroids augment the activity of the parietal cells themselves or may actually increase the parietal cell mass.

It must be remembered that gastric secretory activity is but one measure of the adrenal effect upon the stomach. Adrenal steroids may increase gastric circulation, as shown by Dolcini in animals.[16] Also, the mucous protective barrier is altered (decreased gastric juice viscosity), interfering with repair and delayed healing of gastric erosions.

In summary, there is general agreement that the adrenal steroids are essential for normal gastric secretory activity. Diminished adrenal function is accompanied by decreased gastric function. Addison's disease patients treated with steroids may develop a positive acid response to histamine and even a peptic ulcer. Under conditions of stress the adrenal may act directly on the stomach, augment gastric secretion, interfere with mucosal defense, and cause an acute "stress" ulcer. Chronic stress may "condition" or sensitize the stomach to a constant level of adrenal secretion. In this way the ulcerogenic effects of the hormone would be equally effective with respect to augmenting vagal, antral, and parietal cell secretion or decreasing mucous production and delaying healing. It appears that knowledge of this phase of ulcer production must remain incomplete until more refined methods of studying gastric secretion become known.

Pancreas

Pancreatic endocrine secretion has long been suspect in the etiology of gastroduodenal ulcer. Dragstedt, Poth,[17, 18] and others had observed experimentally that duodenal ulcers may be produced by deviation of the alkaline secretions of the pancreas by external fistulas or by ligation of the pancreatic ducts; and Poth, in 1948, postulated an intrinsic factor of the pancreas not related to its external secretion but active in the pathogenesis of ulcer.

The report, then, by Zollinger and Ellison in 1955,[19] of a fulminating ulcer syndrome associated with a noninsulin-producing islet cell tumor of the pancreas, created great interest. This syndrome is characterized by fulminating, often atypically located peptic ulceration, watery diarrhea, prominent gastric secretion, and hyperacidity, together with the identification at laporotomy of a nonbeta cell adenoma of the pancreas. Approximately 50% of these tumors are reported malignant by Zollinger. Occasionally, a diffuse hyperplasia of the islets with no localized tumor has been seen.

The literature on this subject is large but the papers of Donaldson, Chvojka, and Shay[20-22] have covered the subject well. Glucagon was first proposed as the cause of this excess secretion but has been discarded; however, the actual stimulus remains unknown. It is of great interest that Gregory and Hallenbeck[23, 24] have recently isolated a gastrin-like substance from these pancreatic tumors.

Variants Reported

Several variants of the Zollinger-Ellison syndrome have also been reported. In some of these patients, diarrhea with hypokalemia have long preceded development of the ulcer.[25, 26] On the other hand, Stempien, et al[27] believe that the syndrome of Benign Hypertrophic Hyperchlorhydric Gastropathy, also characterized by high gastric secretion of acid and pepsin, must be distinguished from the Z-E syndrome, as no pancreatic tumor is present in these cases. Spontaneous hypoglycemia stimulates secretion in patients with insulin-secreting tumors of the beta cells but rarely causes duodenal ulcer.[11]

Particularly pertinent in the consideration of endocrine aspects of peptic ulceration is the observation that adenomas or hyperplasias of other endocrine glands may accompany the ulcerogenic tumors of the pancreas. According to Zollinger and Ellison,[21] "the adrenal cortex has shown accompanying hyperplasia most often and less frequently the pituitary, pancreatic beta cell insulinomas, and parathyroids."

Since the first report of Underdahl[28] in 1953, over 60 cases of polyendocrine adenomatoses have been reported. Three of the original 8 cases exhibited peptic ulcer but little was made of this until it was shown that polyendocrine disease is seen in the Zollinger-Ellison syndrome. This disorder seems to be definitely familial and Mieher[29] feels that the Zollinger-Ellison syndrome may be one manner of expression of polyendocrine adenomatosis. Pituitary, pancreatic, and parathyroid adenomas occur in this condition and are frequently multiple. Clinical manifestations depend upon the predominant lesion involved but the ulcer diathesis seems to be associated with a high incidence of pituitary adenomas in this syndrome.[30]

Parathyroid Glands

There have been many reports of peptic ulcer disease associated with hyperparathyroidism. It has long been known that gastrointestinal symptoms are prominent in this condition; hence, the association of the two is easily understood.

Ostrow,[31] in an extensive review, found a 9% incidence of peptic ulcer among 429 patients with primary hyperparathyroidism and feels that proved ulcer is only slightly more prevalent than among the general population. Certainly gastric secretion is probably not increased by the administration of parathyroid hormone, although intravenous calcium salts apparently increase secretion.[32] In these patients, ulcer symptoms generally precede the onset of clinical hyperparathyroidism and sometimes ulcers persist or become worse after removal of the parathyroid adenoma.

Wilder, Frame, and Haubrich,[33] however, feel that the association of ulcer and parathyroid is real despite the lack of correlation with gastric secretion. The possibility that peptic ulcer is a feature of polyendocrine disease in which the parathyroid element predominates must also be kept in mind. It is noted with interest that there is probably an increased familial incidence of hyperparathyroidism, as is true with multiple adenomatosis.

Gonads

Little is known regarding sex hormones and gastric secretion. Peptic ulcer is less common in women of reproductive age than in men, and there is a reduction in the secretion of acid and pepsin during pregnancy.[34] Gastric secretion increases during lactation in the human and dog, and Trulove has suggested that Stilbesterol may be of benefit in duodenal ulcer in man.[35] Obviously no conclusions can be drawn from the few studies available.

Local Hormones

There has been much interest in serotonin (5-hydroxytryptamine) since the first reports of the carcinoid syndrome several years ago. At least 90% of total body serotonin is contained within the digestive system and there is a high concentration of serotonin-producing argentaffin cells within the duodenal mucosa.[36] Although serotonin inhibits the secretion of acid in response to maximal histamine stimulation, the effect is probably central as the effect is largely abolished by vagotomy. Paradoxically, widespread carcinoid tumors are probably associated with an increased incidence of peptic ulcers.[37]

Gastrin Concept

The gastrin concept of gastric secretory activity has been controversial for years. An extract of pyloric mucosa had been known to stimulate gastric glands to secrete, but this substance was thought to be histamine. When a histamine-free substance eventually was obtained, it was found that gastrin is a specific substance, although its chemical structure has not been defined.[38]

There can be little doubt that stimulation of the gastric antrum resulting in gastrin release causes marked increase in secretion in the experimental stomach. There is probably some control via the vagus nerve, but the mechanism of excitation remains in doubt. Distention, irritation, topical acetylcholine, and certain foods can cause gastrin release, whereas acidifying the antral content causes inhibition of release. This last fact is of interest when it is realized that the stimulus of food plus mechanical irritation from the food per se could result in the autoregulation of secretions. A specific inhibitory hormone has not been found. Whether the gastrin mechanism is actually a factor in ulcer is not known. In this regard, the fact that ulcers are more common in liver disease might be of importance. Clarke[39] has recently shown in dogs with portocaval anastomoses that an increase in stomach acid produc-

tion may be due to failure of the liver to inactivate gastrin. However, the fact that gastric secretion in hepatic cirrhosis is often diminished makes this explanation rather weak.

Intestinal Stimulation of Gastric Secretion

The concept of a humoral pathway of gastric stimulation originating in the small intestine has long been considered because of the observation that meals of meat juice cause increased secretion of isolated total gastric pouches.[40] Some have related this to an "antrum-like" effect but the suggestion that L-histidine resulting from histamine after decarboxylation by intestinal bacteria may cause the increased secretion is more likely.[41]

It has been known that fat in the small intestine inhibits gastric activity and the postulation of an hormonal extract of the intestine ("enterogastrone") resulting in decreased activity is well known but not generally accepted. Bile salts and pancreatic lipase are necessary for this fat inhibitory effect and reabsorbed bile salts could be the gastric inhibitor. It has already been mentioned earlier that diversion of bile or pancreatic juice often causes ulcers in experimental animals.[17, 18] Carbohydrates and other substances also inhibit secretion but to a lesser degree.

It can be concluded that the role played by the proximal small intestine in the regulation of gastric secretion is prominent but inconclusive. Biliary and pancreatic secretions and liver function are all factors to be considered. As yet there is no proof that these are of importance in the development of the usual ulcer in man.

Conclusion

In conclusion, the hour-by-hour regulation of gastric secretion is accomplished by vagal nervous impulses and by alimentary hormones, some of which may be stimulatory or inhibitory. The hormones of the major endocrine glands apparently assume a permissive roll in the control of these secretions. Where secreted excessively they may then dominate the regulation of gastric secretion and, depending upon the gland involved, result in hypo or hyper function of the stomach as a secretory organ.

Recent renewed interest in gastrin and duodenal regulatory mechanism is encouraging and worthy of further study. It seems unlikely that the usual ulcer should be closely related to the rare Zollinger-Ellison syndrome but observations of this type greatly increase investigational possibilities. It seems clear that the endocrine glands deserve further consideration in the pathogenesis of ulcer disease.

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(Continued on Page 604)

On Post-Op Bladder Lethargy

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Urinary retention following surgery continues to plague some patients. Measures to minimize the problem, particularly by preventing overstretch decompensation, are discussed.

THE DISTRESSING problem of post-operative bladder failure is still with us and probably always will be. Efforts to relate it to certain kinds of surgery or certain kinds of anesthesia or certain kinds of people have not proved anything except that it occurs now and then with any of these things.

Obviously the main trouble lies with the nervous system, at least initially. When perception centers become cluttered with signals from fresh wounds, ordinary and accustomed sensations like those from a moderately full bladder may be overlooked or misinterpreted. The S.O.S. from a full bladder must be made even fainter by the usual post-operative anti-pain measures.

We cannot explain why a few forty-year-old males with normal prostates cannot void for a day or two after herniorrhaphy and the rest can. The answer, we think, must await the patient research of a good clinical psychologist.

Possible Causes

Aside from this, we can recognize a few circumstances which, if not irrefutably, at least logically, have some bearing on the post-operative status vesicae:

(1) Extensive pelvic surgery such as abdomino-perineal resection and Wertheim hysterectomy turns the pelvis into a fog of edema and cloudy-swelling which could hardly avoid disrupting communications to some extent. This is over and beyond the inevitable snipping of a few nerves heading into or from the bladder. As the fog dissipates, one would expect that normal exchange would be restored in a week or so, and this is consistent with what is usually observed. Pain resulting from such surgery emanates so nearly from the location of the bladder that it must thunderously deafen the perception center to any messages sent along almost the same circuits. Which leads us back to the clinical psychologist. Surgery on the extremities, neck, or even chest seldom causes post-operative bladder problems, while surgery to the kidneys and upper abdomen, though sufficiently removed to avert pelvic fog, causes them more often. We timorously postulate a theorem: The closer any significantly painful surgery is to the bladder, the more likely is the patient to need a catheter.

(2) During anesthesia the voiding mechanism is inert, which is important only in that patients with perhaps half-full bladders entering the operating room for lengthy surgery and destined for a semi-lucid hour or so in the recovery room may reach a state of perception only after the bladder is considerably overdistended. Which leads us into the most significant and sometimes forgotten point of this topic, namely:

(3) Overdistended bladders are temporary cripples. Urologists have long been aware of this, and most of them have reached the conclusion that the duration of crippling effect is a function of the degree of overdistention and of the time it is allowed to persist.

Examples from the urologist's handbook show the extremes. Occasionally, a stoic, elderly

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farmer is encountered who has been voiding frequently for months. His tapped bladder yields 1200 cc. of residual urine which he has obviously been dealing with for weeks. Prompt prostatectomy creates a more normal voiding interval, but may still leave him a residual of 300-400 cc. A period of 4-6 weeks of continuous catheter drainage will usually allow his stretched bladder to compensate and reduce residual to zero where it belongs.

Rapid Overstretch

The slow residual build-up is in marked contrast symptomatically to rapid overstretch. People accustomed to no residual and normal (500 cc.) capacity become frantic as bladder volume quickly mounts to 700-800-900 cc. Distress signals from the distraught bladder eventually effectively compete in the message center, and even the most traumatized of surgical patients become restless and demanding.

Overflow is simply manifestation of a safety-valve acting to prevent extravasation. It occurs long after over-distention.

A quick stretch of 600 cc. is not apt to create a decompensation problem; 700 cc. is more likely to, while 800 cc. and above will almost certainly do so. From a practical management standpoint, whenever it becomes necessary to order a catheter, the amount of urine recovered should tell one what to expect. Volumes of 500 to 600 cc. are compatible with removing the catheter and allowing another try or two. Since repeated catheterizations are more likely to introduce larger variety and numbers of bacteria (not to mention a certain amount of trauma and pain), a volume of 700 cc. is better approached by an indwelling catheter for a week, and volumes of 800 cc. and above may need two weeks or more. It is just as well for both surgeon and patient to have this understood from the first catheterization.

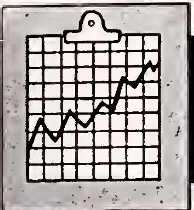
When a formerly hard-working, loyal bladder suddenly refuses to work, it is tempting to lash it on with a cholinergic drug. Undoubtedly physicians and their patients have occasionally witnessed a more normal extrusion of urine with such medication. Our experience, however, contains no instance of this kind which could not be explained equally well by the return of other factors to a more normal state.

Prevention of Decompensation

The prevention of overstretch decompensation with its prolongation of voiding problems is a point worth driving home. It is easy to understand how surgeons and others might reluctantly allow their patients to get into this plight. Just one case of thriving, catheter-induced urinary infection, possibly with an awesome epididymitis, is enough to cloud the reason of the most competent doctor. The profession has become uneasy at the evidence that a single catheterization can start a process capable of wiping out the kidneys some years later. Nevertheless, when observation indicates that our patient should have something close to capacity in the bladder, and his or her efforts to void have been reasonable and fruitless, catheterization then and not three hours later is clearly justified.

Once this stage has been reached, efforts to prevent infection should follow. A good urinary antibiotic continued for 3-4 days after catheterization makes sense. Use of a coudé (curled tip) catheter minimizes trauma in the male, is readily directed in the female, and is less apt to create abrasions vulnerable to bacteria. For the fastidious, germs clinging to the catheter and remaining in the bladder can be left bathed in 5% mild silver protein. One should also examine the urine in the follow-up period for evidence of asymptomatic infection and continue whatever measures this indicates.

The elderly male patient sometimes makes a special problem. However, with an accurate history of minimal pre-operative voiding symptoms, even the obvious presence of a moderately enlarged prostate should not usually call for resection. The wary and conscientious urologist dislikes resection of a prostate which is relatively innocent. Fortunately for those who are operated on the period required for compensation of acute over-stretch is usually about over anyway.



CASE DISCUSSIONS
From The
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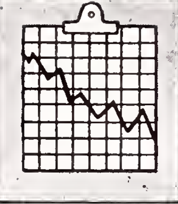

Louisville General Hospital

Attempted Suicide: A Four Month Study

Nina Bess Goss-Moffitt, M.D.*

THE problem of suicide attempt aroused the interest of the Psychiatry Service of the Louisville General Hospital when an increase in the number of patients with this presenting symptom became apparent. A suicide study was done, and herein we present our findings for the four-month period from December 1, 1962, through March 31, 1963.

There is a remarkable opportunity for making such a study, as attempted suicide constitutes a misdemeanor in Jefferson County. The patients are charged with disorderly conduct and, before they are released, are brought to the Louisville General Hospital by the police for treatment and evaluation by the psychiatric service.

During the survey period, 120 such patients were seen. Of these, 93 were admitted; eight minors who made very superficial suicidal gestures were released to responsible members of their families, with arrangements made for clinic or private follow-up; one was transferred to a private hospital; and the remainder were returned to the police, either because the patient preferred jail to hospitalization and/or because the patient's condition obviously did not warrant admission.

In our organizational system, the patient is first seen in the emergency room by the medical or surgical service and immediate treatment is begun, as indicated by the patient's condition and the means employed in his suicide attempt. The poison control board, available at all times, is very helpful in advising the management of patients taking commercial poisons and over-dosage of patient medications. The surgical service handles all gunshot wounds and lacerations. Patients who have consumed large amounts of depressant medication, and who are stuporous or comatose on arrival, are admitted to the Recovery Room and treated by the Anesthesia Department until they have reacted. If this excellent cooperation did not exist between services, many of these patients would be successful suicides rather than mere attempts. In the series, there were only two deaths, both patients being female, both having taken a massive dose of barbiturates and having been received in coma, and both having developed pulmonary complications, viz., aspiration pneumonia. Neither of these patients was gavaged, as it is the opinion of the Anesthesia Department that no patient in coma should be gavaged because of the serious hazard of aspiration and its consequent morbidity.

We do not include in this series any patient dead on arrival from suicide.

When the initial resusitative or surgical measures have been accomplished, all of these patients are then seen by a member of the Psychiatry staff, and, as stated earlier, most of the patients are admitted to the psychiatric service for careful evaluation.

Several interesting findings have arisen from this survey, some of which are contrary to what is usually described in the literature about suicide. These patients constituted 27% of the total admissions to our psychiatric service during the four month study. A gradual rise is being shown in this type of admission and there is no prediliction for spring and fall. The highest number was in the month of December. (See Graph No. 1) The number of women

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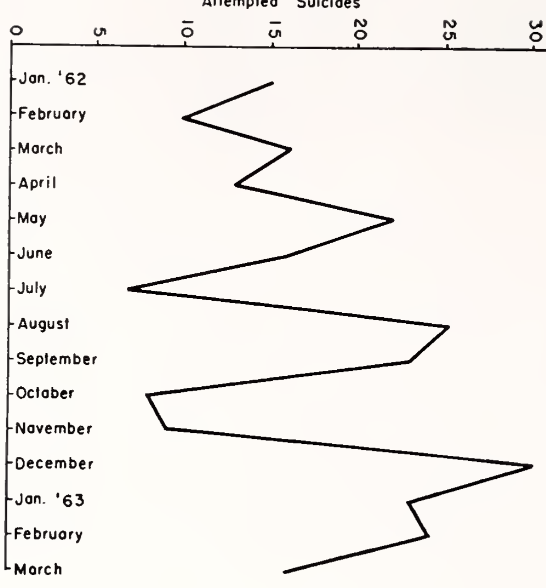
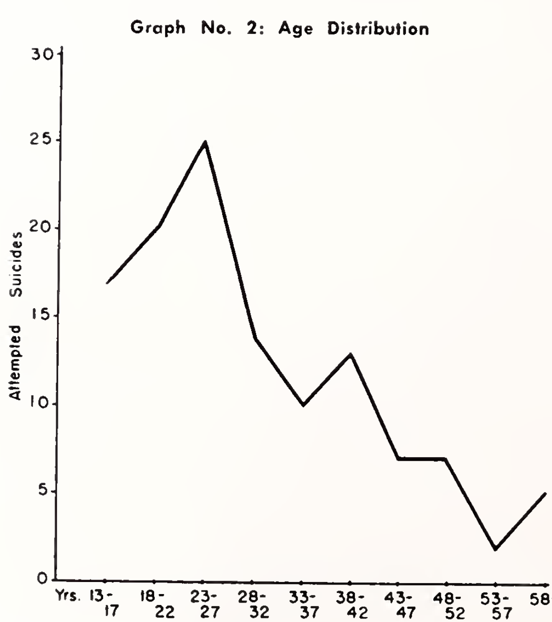
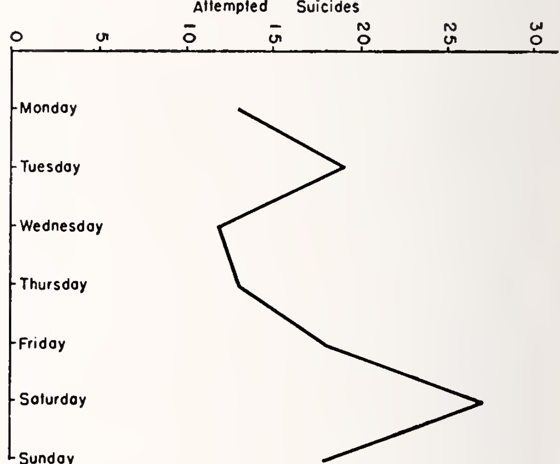


attempting suicide is nearly double that for males—76 women and 44 men. One hundred five, or 86%, were Caucasian and the remaining 15, or 14% were Negro.

The age distribution (see Graph No. 2) is highest in the late-teen through mid-twenty group and gradually *decreases* with age. The youngest in our series was 13 and the oldest 81. Forty-eight were married, 21 had been married and were divorced, and 17 were under 18 years of age. Further, most of the patients were not suffering from a true depressive illness, but seemed to be in a state of temporary unhappiness related to a trying and troublesome situation. Most did not really desire to die but were reacting impulsively or were attempting a secondary gain in their life situation. Most were either found to fit into the diagnostic categories of adjustment reactions or, more frequently, emotionally unstable personality disorders. A smaller number were sociopathic in make-up. There were only 13 psychotic patients. Eleven of these were schizophrenic and only one each involutional and psychotic depressive. There were two mental defectives and two epileptics.



Exclusive of the psychotic group, nearly 100 per cent were genuinely glad to have survived and, within a matter of hours following recovery, were cheerful, alert, and interested in finding a workable solution to their problems, or in making plans for returning to their families, jobs, and responsibilities. They admitted that their action had been silly and said that they would never try it again. However, we found that it was the second attempt for 25 of the admissions, the third attempt for three, the fourth for two, the seventh for one, and the eleventh for one. (See table.) This means 27% were repeaters.



No. of patients	No. of attempts	Per cent
88	1st	74
25	2nd	21
3	3rd	3
2	4th	1
1	7th	0.5
1	11th	0.5

Saturday, was the most popular day for suicide, followed considerably behind by Tues-

day, and then Friday and Sunday sharing equal popularity. Wednesday was the least frequently chosen day. (See Graph No. 3) Every hour, with the exception of 6 A.M., was implicated as the time for suicide, but 7 P.M. was the most frequent hour, with 12 patients attempting at that time. 10 P.M. was next in frequency with nine patients. 2 A.M. and 8 A.M. followed with seven each, and 5 P.M. and 1 A.M. with six. 2 P.M., 4 P.M., 12:00 midnight, and 9 A.M. all had five.

The methods used were as follows (see table). Twenty-four used more than one means, but the most serious only was listed.

Method employed	No. of patients
Barbiturates	33
Lacerated wrists	26
Tranquilizers	15
Acetylsalicylic Acid	12
Natural gas	7
Doriden®[1]	5
Chloral hydrate	2
Antihistamines	2
Iodine	2
Cut throat	2
Paint thinner	1
Ergot	1
Butazoladin®[2]	1
Drowning	1
Rat poison	1
Roach poison	1
Sominex (patent medicine)	1
Dilantin®[3]	1
Codeine	1
Sno-Bowl (caustic toilet cleanser)	1

Twenty-seven of the patients required admission to the Recovery Room for treatment and, of these, 15 had taken barbiturates, six Doriden®, four Librium®[4], one Placidyl®[5], and one paint thinner.

Only a few patients wrote suicide notes or seemed to have given much serious thought to planning their suicide. Also, most attempts were made after informing someone of their intent; with family present; shortly before family would be expected to arrive; or, after making the attempt, they called for help.

However, it is still our feeling that no suicide attempt should be taken lightly, that many would be fatal if not given prompt and adequate medical care, that all patients who attempt suicide should be carefully evaluated, and that many need help even though they may not have true depressive illnesses.

The following case report is rather typical of the majority of the patients in this series:

B. J.: This 24-year-old, white, married female was brought to the hospital at 6:30 P.M. by the police after she had taken twelve 3-grain capsules of sodium pentobarbital in a suicidal attempt, about one hour before admission. In the emergency room, she was quite drowsy but could respond to verbal stimuli. All vital signs being normal, she was gavaged, and then admitted to the Psychiatric service. Routine intravenous fluids were started. She remained in a rather sleepy state for approximately eight hours, with gradual clearing. Other than the somnolence, the basic homeostasis was maintained. As she became more alert and aware of her surroundings, she was indignant at being hospitalized in a psychiatric service and loudly declared that she was not "crazy." She stated she did not truly desire to kill herself, but only wanted a rest.

When the patient was told that charges had been placed against her by the police and that she could not be released until her true mental condition could be evaluated, a marked change occurred in her attitude. She then became very cooperative, entered freely into ward activities, and her mood was appropriate to the situation. She stated that she had been having some marital difficulties, that her husband had been drinking excessively, and was occasionally physically abusive to her. He had been unemployed for over a year, they were heavily in debt, and she was burdened with the care of three young children and her household duties. They had been living only on his unemployment compensation, which had now run out. The actual precipitating event which led to her suicidal attempt was that her husband came in drunk and with lipstick on his collar. A bitter argument ensued, and she ran into the bathroom and took the 12 capsules. Shortly afterward, she panicked and told her husband what she had done. He called the police, who brought her to the hospital.

The patient was from a lower middle class background, had quit school at the age of 17 to marry, and her first child was born a year later. Her husband had attended high school for two years and worked as a common laborer. They had had financial difficulties throughout their

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[1]Doriden, Glutethimide N. F., *Ciba*
[2]Butazolidin, Brand of Phenylbutazone, *Geigy*
[3]Dilantin, diphenylhydantoin, *Parke-Davis*
[4]Librium, Chlordiazepoxide, *Roche*
[5]Placidyl, Ethchlorvynol, *Abbott*

marriage, and frequently argued. The patient was of low average intelligence and possessed very few inner resources. She felt trapped in her situation and could see "no other way out" at the time of her suicidal attempt.

On the second day of hospitalization, the husband visited the patient and, feeling very guilty about his contribution to her suicidal gesture, promised to "straighten up" and was diligently looking for work. The patient thereafter was very cheerful, pleased with the results her crisis had wrought, and left the hospital with great expectations. She failed to keep her appointment for follow-up in the outpatient clinic.

Our department plans to continue its study of suicides in an intensive fashion, especially as it relates to the younger and less mature group of patients.

DISCUSSION

S. Spafford Ackerly, M.D., professor and chairman, department of psychiatry, University of Louisville School of Medicine: This is a distressing problem that sooner or later will face every physician who assumes responsibility for patient care. As Dr. Goss stated, suicidal threats or attempts cannot be taken lightly, even though the element of secondary gain is prominent. We have all wished we had as much foresight as hindsight in this regard at least once in our practice. It is of interest to see wherein the figures in this preliminary study coincide with national ones. In some national studies, suicide is accomplished more often by males than by women, though women make more frequent attempts. On the list of major causes of death, successful suicide is 4th in men, exceeded only by accidents, heart disease, and cancer, and 5th in women. In Negro males it is 8th, and in Negro women 10th. As inferred by the large number in the present study who apparently tried to gain some indirect advantages from their suicidal attempts, such inferences are common in literature. One paper summed up the matter as follows: "In many instances, the suicidal attempt was undoubtedly an hysterical, impulsive, revengeful, manipulative act rather than the expression of a true death wish." (Oltman and Friedman, 1962)

I am glad to know the author of this excellent paper is continuing her study of this important public health problem.

Plan Now To Attend

The KSMA Annual Meeting

Phoenix Hotel, Lexington, Ky.

September 23 - 26

EDITORIALS

The A. M. A. Department of Medicine And Religion

EIGHTEEN months ago the American Medical Association officially established a Department of Medicine and Religion and invited Dr. Paul McCleve, a Presbyterian Minister, to join the A.M.A. as Director. Since October, 1962 pilot programs have been carried out in County Medical Societies scattered over the country in order to explore activities that may be appropriate and constructive. This spring 25 states had endorsed and set up mechanisms for cooperating in this new program. On June 6, 1963 the Board of Trustees of the Kentucky State Medical Association appointed a committee to represent our Society and to officially activate the program here. The overall plan has been defined in four separate endeavors: (1) Physician-Clergy relations in total patient care; (2) Hospital Chaplaincy and Clinical Pastoral Education; (3) Medical School and Nursing School Education; (4) Theological Education.

Sunday Evening, June 16th during the meeting in Atlantic City this new department held an open forum for visiting physicians and their wives and for local residents. Both Medicine and the Church provided speakers. The department thus officially began its participation in the vast A.M.A. program of public service.

Medicine and theology are both professions of service. A large number of physicians are the sons of ministers and as a usual thing they become effective and outstanding members of the profession. They have been reared in an atmosphere of service to mankind. They have chosen medicine because it seems to offer them a wider field of activity with fewer restrictions both morally and financially, but they have generally carried into the profession of medicine the same basic moral concepts practiced in their home by their minister fathers. Conversely, quite a few sons of physicians find the ministry a more effective avenue of service. It is then appropriate that during the past generation the two professions have come to a closer understanding and have drawn upon the resources of each other in their daily activity.

For long a myth has been abroad that a conflict exists between religion and science and that men of science, most especially physicians, take a dim view of religion in general, practice it with marked indifference if at all, and often deny its reality. On the contrary, the physicians with whom we come in daily contact are in the majority of instances active members of some church; they are positive in their religious belief; they practice Christianity in their profession daily; they contribute substantially of their time and money to the support of the church and its activity. Comparing a given number of physicians selected at random with an equal number of persons from other walks—teachers, farmers, housewives, salespeople, executives—their interest and active participation in church and civic affairs will match favorably anywhere.

Just what can be accomplished by this new Department of Medicine and Religion in the American Medical Association and constituent state societies remains to be seen. It will depend largely upon the resourcefulness and energy of those entrusted with its development. There is surely a field of promise for improvement in general patient care. We as an organization and as individuals owe it our enthusiastic support.

Sam A. Overstreet, M.D.

It's Not Too Late

A FEW short weeks ago you could not pick up a newspaper without the word "Thalidomide" staring you in the face. The public was aroused to a high fervor, radio and television blared, and it was demanded that our elected representatives take action as the result of this tragedy.

The New York Times reported that there were approximately 4,000 deaths and deformities over the entire world due to the use of this drug. The figure is less than 1% of the traffic fatalities for the United States in 1962. Yet, the public does not seem to get too upset over the highway massacre.

Each year for the past 10, there have been between 700-800 citizens of Kentucky needlessly slaughtered on our highways. Although there are some bright spots of progress, the over-all picture is a tragic one filled with death, injuries and millions of dollars lost in property damage.

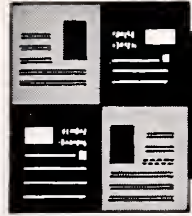
Suppose our citizens were informed that during the next 10 years the entire combined populations of Shelbyville and Georgetown or every child in the Lexington school system would be destroyed. The shock of such a statement would create the necessary action within our State to prevent such an occurrence. Yet, a similar number of our state citizens will have lost their lives on our highways at the end of the next 10 years if the present rate of traffic fatalities continues.

During the three years of the Korean War, many homes were shocked to learn of the 33,629 Americans who lost their lives on the battlefield, an average of 11,210 a year. Last year alone, 41,000 Americans met death on our Nation's highways. Why then is there such very little public clamor and very little support for needed traffic safety legislation?

Every state that surrounds us has a death rate per 100,000,000 miles that is less than Kentucky's. This slaughter can and must be curbed.

Twentieth century tools are needed. A strong stand and initial medical steps have been taken by Kentucky physicians, the Department of Safety, the Department of Health and the U. S. Public Health Service in joint meetings sponsored by the Kentucky State Medical Association. The definition of "driver limitation," even within broad boundaries, will help all concerned. Every physician must be cognizant of both his personal and public responsibilities to curb this spiraling mortality and morbidity.

R. Arnold Griswold, M.D.



SPECIAL ARTICLES

Medical Responsibilities In Driver Licensing

Arthur H. Keeney, M.D.†
Louisville, Ky.

THE PRESIDENT and Highway Safety Committee of the Kentucky State Medical Association were hosts to a recent conference of remarkable unaniminity on formalizing the basic steps in medical limitation of driver licensing in Kentucky.

Preliminary studies were initiated June 23, 1961, by conference at the Police Academy in Frankfort, when the Commissioner and Deputy Commissioner of Safety requested KSMA to prepare a prospectus of medical standards in driver licensing. These were developed by the Highway Safety Committee. The sensory problems were analyzed in detail at an open meeting of the Louisville Eye and Ear Society (October 16, 1961), where four Department of Safety officials were participating guests.

In November 1961, the Kentucky Chapter of the American College of Physicians, The Kentucky Orthopedic Society and The Kentucky Psychiatric Association were solicited for opinions in this field. Revised constructions were then personally presented to the Commissioner of Health and the Commissioner of Safety in Frankfort, December 13, 1961. Both department heads verbally approved the outlines and submitted them to their legal sections for analysis.

Beyond obvious implications of common sense, the basic aim of these steps has been to implement the longstanding but lightly guarded provisions of KRS 186.44, charging state police *not* to grant an operator's license to any person "afflicted with such physical or mental disability as prevents him from exercising reasonable and ordinary control over a motor vehicle upon the highway."

This program seeks no new legislative measures but begins to clarify and implement the soundness of established Kentucky Statutes. It will not replace current screening or testing procedures used by the Division of Driver Licensing, but will augment them.

The working concepts in driver limitation are not to single out drivers because of age but rather in terms of functional capacity. Similarly, disorders which are adequately treated, controlled or compensated for are no concern of this program. Thus, a well controlled epileptic or diabetic, or an amputee with suitable prosthetic devices is of no concern to driver safety. However, an uncontrolled epileptic, one with uncontrolled "blackouts," a poorly controlled diabetic with visual loss, or a cardiac with resting dyspnea are distinct medical problems in driver limitation. Attention is focused both on single pivotal disorders and combinations of lesser defects which, in a physician's judgment, may impair safe vehicle operation.

On May 8, 1962, the Legislative Research Commission in Frankfort created a 16-member Advisory Committee on Automotive Safety under the chairmanship of William K. Keller, M.D. An initial activity of the commission staff* was to evaluate implementation of driver limitation in the licensing program of the Department of Safety. The staff wrote (July 12, 1962) that such additional rules would not be "an unconstitutional delegation of legislative authority to the Department of Safety."

A further conference on visual screening was

†*Chairman, Highway Safety Committee, Kentucky State Medical Association*

**Mr. Charles Wheeler, Mr. Dale Bryant and Mr. Russell Jewert*

held with Lexington and Louisville ophthalmologists of the Highway Safety Committee at the Police Academy Library, June 7, 1962, in an effort to simplify these tests.

The January 1963 issue of The Journal of KSMA stated editorially the position of the committee in meeting January 3, 1962, under the title "Driver Limitation and Smallpox" (p. 48). This was promptly picked up by Kentucky newspapers in anticipation of the definitive meeting, February 21, 1963.

The February 21 meeting culminated a year and eight months of planning and brought together: accident prevention officers from the USPHS Region III office, Charlottesville, Va.; our Commissioner of Health and his staff; the Administrative Staff of the Department of Safety; the Kentucky State Health and Welfare Agency; the Legislative Research Commission; and the President of the KSMA.

Highway Safety Committee members, by virtue of other appointments, also represented the Board of Directors of the American Association for Automotive Medicine, the AMA Committee on Medical Aspects of Automotive Safety, the American College of Surgeons Committee on Trauma, the Governor's Safety Advisory Committee, and the Advisory Committee on Highway Safety to the Legislative Research Commission.

This group promptly and unanimously concurred in:

A. The general areas of medical limitation to motor vehicle operation as proposed by KSMA in 1961;**

B. The exclusion of age per se as driver limitation, in deference to functional capacity of the individual;

C. The recognition of psychiatric disturbances as significant factors in accidents, but the exclusion of most specific psychiatric diagnoses because of currently insurmountable screening difficulties. The point system, which revoked nearly 1,700 Kentucky licenses in 1962, will continue to be relied upon to curb behavioral offenders;

D. The principle that only untreated, uncompensated, or intractable medical limitations are of concern in vehicle operation;

E. The principle that limitation may be created by either a single major impairment, or multiple minor impairments which would collectively render the operator unsafe;

F. Maintenance of current screening and examining procedures as in effect by the Division of Driver Licensing, so that these administrative steps would supplement rather than replace existing measures;

G. The basic need and expectation of sound, responsible and individual judgment by physicians in each case;

H. The coordinated review of recipients of Aid to the Needy Blind, Treasury Department exemptions granted for visual loss, and narcotic institution patients, so that licenses in such circumstances will be automatically revoked;

I. The inherent right of appeal and the establishment of medical review and appeal boards;

J. The need to proceed promptly with administrative rules and regulations thus carrying out the charge of KRS 186.440.

As this program moves into operation, examination for driver limitation will be required by the Department of Public Safety when (1) a license applicant displays obviously impaired abilities, (2) a driver has been involved in three accidents in a 24-month period, or (3) a driver must be placed in the "assigned risk" pool for insurance underwriting, or (4) a driver voluntarily suggests that he "blacked out" or that medical problems contributed to an accident. Examinations may be done by private physicians at the individual's expense, or without cost at several designated county health departments. A flow pattern of reporting between the Department of Health and Safety is now being finalized.

This program will add some further responsibilities to shoulders of many physicians who certainly are not looking for additional "forms." The mature recognition of medical limitation in driving is incumbent, however, not only upon each driver, but upon individual physicians who are manifestly responsible for such decisions.

***In the main these parallel the AMA Medical Guide for Physicians in Determining Fitness to Drive a Motor Vehicle (1959), Physical Standards for Driver Licensing, Commonwealth of Pennsylvania (1960), and the Guide for Physicians in Determining Fitness to Drive a Motor Vehicle, British-Columbia (Oct. 1962).*

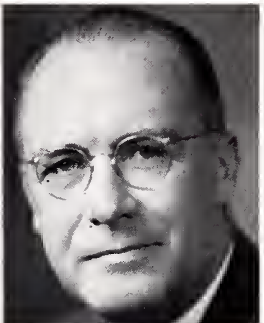
ORGANIZATION SECTION

Outstanding Specialists From Varied Fields Will Address 1963 KSMA Annual Meeting in Lexington Sept. 24-26

Fourteen noted specialists from the leading fields of medicine will be guest speakers of the 1963 Kentucky State Medical Association Annual Meeting to be held at the Phoenix Hotel in Lexington September 24-26.

Urging all Kentucky physicians to attend, David M. Cox, M.D., KSMA president, called the 1963 program an important and outstanding one. Doctor Cox recently released biographical information on four featured speakers who will take part in the general scientific session as the guests of various specialty groups. A complete roster of guest speakers will appear in the August issue of The Journal.

H. H. Ware, M.D., Richmond, Va., obstetrician and gynecologist, a guest of the Kentucky Obstetrical and Gynecologic Society, will take part in a panel discussion on "Etiologic and Therapeutic Aspects in Pyelonephritis" during the general scientific session on Tuesday afternoon, September 24, at 2 p.m. He will address his host specialty group on Tuesday morning on the topics, "Studies and Management of Ectopic Pregnancy", and "Varied Aspects in Diagnosis and Treatment of Ectopic Pregnancy".



Doctor Ware

Doctor Ware, professor and chairman of the department of obstetrics and gynecology at the Medical College of Virginia in Richmond, is a 1924 graduate of the same school.

Paul W. Sanger, M.D., Charlotte, N.C., will present the chest physician's view during a general session panel on "Environmental Factors in Lung Cancer", on Thursday, September 26, at 11 a.m. He will also address his hosts, the Kentucky Chapter, American College of Chest Physicians, during their meeting on Thursday afternoon. The title of Doctor Sanger's address will be announced at a later date.

Doctor Sanger

A graduate of Vanderbilt University Medical School, Doctor Sanger is a diplomate of the American Board of Surgery and a member of the Board of Thoracic Surgery.

Charles A. Perera, M.D., the guest of the Kentucky EEN&T Society, is a professor of ophthalmology at the College of Physicians and Surgeons, Columbia University. As a participant in the panel discussion on "Tumors of the Head and Neck", he will present the EEN&T aspects of this problem at 9 a.m. Thursday, September 26. Doctor Perera will also discuss "Technical and Surgical Problems in Strabismus" before his host group at its specialty meeting on Thursday afternoon.

Doctor Perera

Doctor Perera received his A.B. from Princeton University, and his M.D. from Columbia in 1930. He is a diplomate of the National Board of Medical Examiners and of the American Board of Ophthalmology.

Bernard Holland, M.D., Atlanta, will participate in the KSMA Annual Meeting as the guest of the Kentucky Psychiatric Association, and will speak to that group at its specialty meeting on Tuesday afternoon, September 24. The topic of his discussion has not yet been announced. In addition, Doctor Holland will participate in a panel discussion on "Obesity" at 9 a.m. Wednesday, September 25.

Doctor Holland

A graduate of Emory University School of Medicine in 1943, Doctor Holland holds the position of professor and chairman of the department of psychiatry at Emory.

A digest of the actions of the AMA House of Delegates at its 1963 Annual Meeting in Atlantic City June 16-20, together with a list of all Kentucky physicians attending this meeting, will appear in the August issue of the Journal. Due to the nearness of the AMA meeting to the deadline of this issue we were unable to have a full report.

Doctors Denham, Sanders Win Nominations

Mitchel B. Denham, M.D., Maysville, and Roy Sanders, M.D., Dorton, were nominated in the May 28 primary elections as Democratic candidates for state representative from their respective districts, according to a release of election results.

The incumbent from the 70th district, Doctor Denham, has been a general practitioner in Maysville for nearly 20 years. He is a member of the KSMA Board of Trustees and a member and former chairman of the KSMA Rural Health Committee. While serving in the Legislature, he has been chairman of numerous house committees.

Doctor Denham carried every precinct in Mason and Bracken Counties, which comprise the 70th district. He received a vote of 4,027 to his opponent's 1,564. Doctor Sanders carried the 93rd district by a vote of 1,432, a margin of 299 over his closest challenger.

Doctor Sanders, a Pike County general practitioner for 35 years, served from 1950-1952 as representative from his present (93rd) district.

Doctor Overstreet Named To Ky. Health Board

Sam A. Overstreet, M.D., Louisville internist and Editor of The Journal of KSMA, was named a member of the State Board of Health by Governor Bert T. Combs, it was announced recently.

Doctor Overstreet

Doctor Overstreet, a past president of the Kentucky State Medical Association and of the Jefferson County Medical Society, has held many other offices in both organizations. He is a former Speaker of the House of Delegates of KSMA and former Governor of the Kentucky Chapter, American College of Physicians.

A 1923 graduate of the University of Louisville School of Medicine, he is professor of medicine at U. of L. He has been president at various times of the medical staffs of Kentucky Baptist Hospital and Methodist Evangelical Hospital, and chief of medical service at St. Joseph Infirmary in Louisville.

AMA Names General Counsel

Robert B. Throckmorton, Des Moines, Iowa, has been named general counsel of the AMA effective July 1, according to an announcement by F. J. L. Blasingame, M.D., AMA executive vice-president.

Throckmorton, a 1939 graduate of Harvard Law School, succeeds C. Joseph Stetler, who resigned to become executive vice-president and general counsel of the Pharmaceutical Manufacturers Association in Washington, D.C. Throckmorton, 47, a member of a Des Moines law firm, has been counsel for the Iowa Medical Society since 1955.

Doctor Robert Long Named To AMA Board of Trustees

Robert C. Long, M.D., Louisville obstetrician and gynecologist, and senior Delegate to AMA from the KSMA, was elected a member of the Board of Trustees of the American Medical Association at the Association's annual meeting in Atlantic City, N.J., last month.

Doctor Long

Doctor Long has been active in organized medical affairs since he entered private practice in Louisville in 1947. Among his many activities in county, state, and national medical organizations, Doctor Long has served as a delegate from the KSMA to the AMA since 1956, chairman of the Reference Committee on Legislation and Public Relations at the 1963 AMA Annual Meeting, and as a member of the National Speaker's Bureau of the AMA.

Within the Kentucky State Medical Association, he has been a member, as a delegate to the AMA, of the Board of Trustees since 1956, chairman of the Committee on Infant and Maternal Mortality, a member of the Committee on Federal Medical Services, and chairman of the Medicare Review Committee. He made the race with the full support of the KSMA Board of Trustees.

Doctor Long has been secretary of the Jefferson County Medical Society, chairman of the Public Relations Committee, the Salk Polio Campaign in 1957, the Specialty Study Group Commission, and the Legislative Committee in 1963.

An assistant professor in the department of obstetrics and gynecology at the University of Louisville School of Medicine, Doctor Long is also a member of the American College of Obstetrics and Gynecology and has served as District V, chairman of the Committee on Medical Service Plans of the ACOG. He is a Diplomate of the American Board of Obstetrics and Gynecology.

Following his graduation from the University of Louisville School of Medicine in 1940, Doctor Long served as a flight surgeon with the U.S. Army Air Force during World War II. He was awarded the Bronze Star while serving in the China-Burma-India Theatre, and attained the rank of Major before separation from service in 1945.

The number of known active cases of tuberculosis in Kentucky has increased to 3,298, according to a recent announcement by the State Department of Health. Last year's total was 2,308. The increase in active cases was attributed largely to better reporting and case finding.

Robert Lich, Jr., M.D., professor of urology at the University of Louisville School of Medicine, was a visiting lecturer at the University of California School of Medicine June 3-10.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

In Kentucky

JULY

26-27 Park Seminar, Kentucky Academy of General Practice, Jenny Wiley State Park, Prestonburg, Ky.

AUGUST

18 Bluegrass Symposium, Kentucky Academy of General Practice, Phoenix Hotel, Lexington, Ky.

28-29 Cave Area Seminar, Kentucky Academy of General Practice, Diamond Caverns Hotel, Park City, Ky.

SEPTEMBER

19 University Surgery Day, University of Kentucky, Lexington, Ky.

23-26 KSMA Annual Meeting, Phoenix Hotel, Lexington, Ky.

27 Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

OCTOBER

4-5 Sudden Cardiac Death Conference, University of Kentucky Medical Center, Lexington, Ky.

10 Maysville Seminar, Kentucky Academy of General Practice, Mason City Health Building, Maysville, Ky.

17 University Surgery Day, University of Kentucky, Lexington, Ky.

18-20 Pediatrics Postgraduate Course, Children's Hospital, Louisville, Ky.

23 Review of Current Problems in Obstetrical Anesthesia, U. of L. School of Medicine, Louisville General Hospital, Louisville, Ky.

24 Rural Health Conference, Jenny Wiley State Park, Prestonsburg, Ky.

24-26 Hematology Course, University of Kentucky, Lexington, Ky.

25 Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

NOVEMBER

6 Annual Fall Clinical Conference, Lexington Clinic, Lexington, Ky. Morning: Rheumatoid Arthritis; Afternoon: Specialized Diagnostic Techniques.

9 Regional American College of Physicians, Holiday Inn, Lexington, Ky.

14-16 Clinical Application of Newer Immunological Concepts, Department of Pediatrics, University of Kentucky, Lexington, Ky.

21 University Surgery Day, University of Kentucky, Lexington, Ky.

29 Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

DECEMBER

5-7 The Family Physician's Role in the Pre and Post Operative Patient, Department of Surgery, University of Kentucky, Lexington, Ky.

19 Annual Postgraduate Seminar, Norton Memorial Infirmary, Louisville, Ky.

19 University Surgery Day, University of Kentucky, Lexington, Ky.

27 Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

Surrounding States

SEPTEMBER

20-21 National Rural Health Conference, Arlington Hotel, Hot Springs, Ark.

OCTOBER

5-10 American Academy of Pediatrics, Palmer House, Chicago, Ill.

5-11 Annual Otolaryngologic Assembly, University of Illinois College of Medicine and Illinois Eye and Ear Infirmary, Chicago, Ill.

24-26 Annual Course in Postgraduate Gastroenterology, American College of Gastroenterology, Shoreham Hotel, Washington, D.C.

28-Nov. 1 American College of Surgeons, Brooks Hall, San Francisco, Calif.

NOVEMBER

11-15 American Public Health Association, Kansas City, Mo.

18-21 Southern Medical Association, Municipal Auditorium, New Orleans, La.

Mrs. Roles Installed at AMA

Mrs. Nancy E. Roles, Louisville, was installed as regional vice-president of the American Medical Association Woman's Auxiliary on June 19 at the AMA Annual Meeting in Atlantic City.

Mrs. Roles

Mrs. Roles, a past president of the KSMA Woman's Auxiliary, is the wife of Earl W. Roles, M.D., Louisville general surgeon.

In addition, Mrs. Roles was the first woman to serve on the Board of Directors of the Amercian Medical Political Action Committee. She was named to this post in 1961. A past president of the American Association of University Women, she has been active in civic affairs, and has held other offices in the Woman's Auxiliaries of organized medicine, both local and national.

Lexington Deaf Oral School Serves Central Kentucky

The Lexington Deaf Oral School was inaugurated less than two years ago for the purpose of training congenitally deaf pre-school children so that they may be better prepared to attend other special schools for the deaf at the appropriate age.

The school serves children between the ages of 3 to 6 years, and is under the direction of Miss Norma Harris, principal and teacher of the deaf. The full tuition is $440 per year for eleven months training. However, families who cannot pay full tuition are asked to contribute in accordance with their ability to pay.

The school has recently been accepted as a participating member of the Fayette County United Community Fund but serves children not only from Fayette County but from other surrounding counties.

Physicians who are aware of congenitally deaf children in this age group who might benefit by this program should contact Miss Norma Harris, P.O. Box 8123, Lexington, Kentucky. This information is brought to the attention of Kentucky physicians since the facility is the only one of its kind available to children with this handicap in Central and Eastern Kentucky.

T. R. Davies, M.D., Barbourville general practitioner, received the Alumni Award presented at Union College's commencement exercises June 3. Doctor Davies is a member of the 1923 graduating class at Union, and a member of the alumni board of directors. He has also served as a trustee. Doctor Davies is a 1930 graduate of the University of Louisville School of Medicine.

KSMA Trustees Will Support Suitable Hospital Action*

The KSMA Board of Trustees at its June 6 meeting in Louisville promised its support of "appropriate legislation" relative to the proposed operation of the Eastern Kentucky chain of hospitals by the Board of Missions of the United Presbyterian Church.

Governor Combs

The trustees agreed to support any suitable action taken by a possible special session of the Kentucky Legislature, provided that negotiations are successful between the Presbyterian Church, the Area Redevelopment Administration, and the UMWA, and result in the operation of the hospitals by the church group.

The Board took this action after Kentucky Governor Bert T. Combs and his assistant, Felix Joyner, appeared before the trustees to discuss the problems involved in the hospital situation.

The governor was introduced by James B. Holloway, M.D., Lexington, chairman of the KSMA Hospital Committee, who gave a brief and concise background of the developments. Doctor Holloway said, "Chaos will undoubtedly develop if these hospitals are closed."

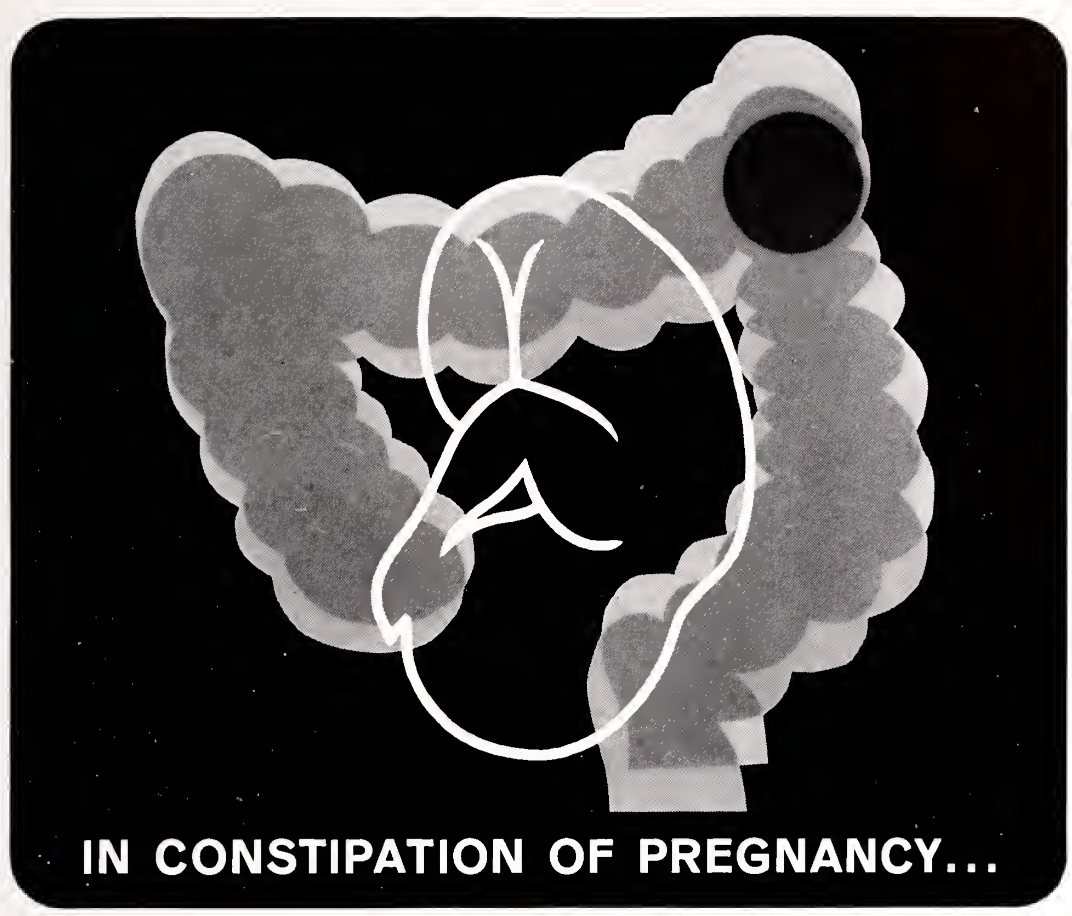
The governor said that it is the intention of the Presbyterian Board of Missions to create a national non-profit hospital authority and that the state of Kentucky is to appropriate the amount indicated as necessary by the indigent medical patients. The state is to take such legislative action as necessary to create the regional hospital authority.

Following the governor's presentation, the Board of Trustees passed the following motion: "We are gravely concerned about the abandonment of the hospitals in Eastern Kentucky by the UMWA. We now express our support of appropriate legislative efforts by the State Government to insure continued operation of these hospitals so that the urgent hospital needs of our distressed people in the Appalachian Mountain area might be met."

In a second motion the Board expressed appreciation to Governor Combs "for his diligent efforts in the very important matter of keeping these hospitals open."

Glenn U. Dorroh, M.D., Lexington, was elected president of the University of Kentucky Alumni Association on June 1. Doctor Dorroh, an internist, is a 1931 graduate of the University of Louisville School of Medicine.

**At press time the General Assembly had been called into special session and was considering legislation proposed by Governor Combs. The governor called the special session following a grant made by the ARA for the purchase of the hospitals.*



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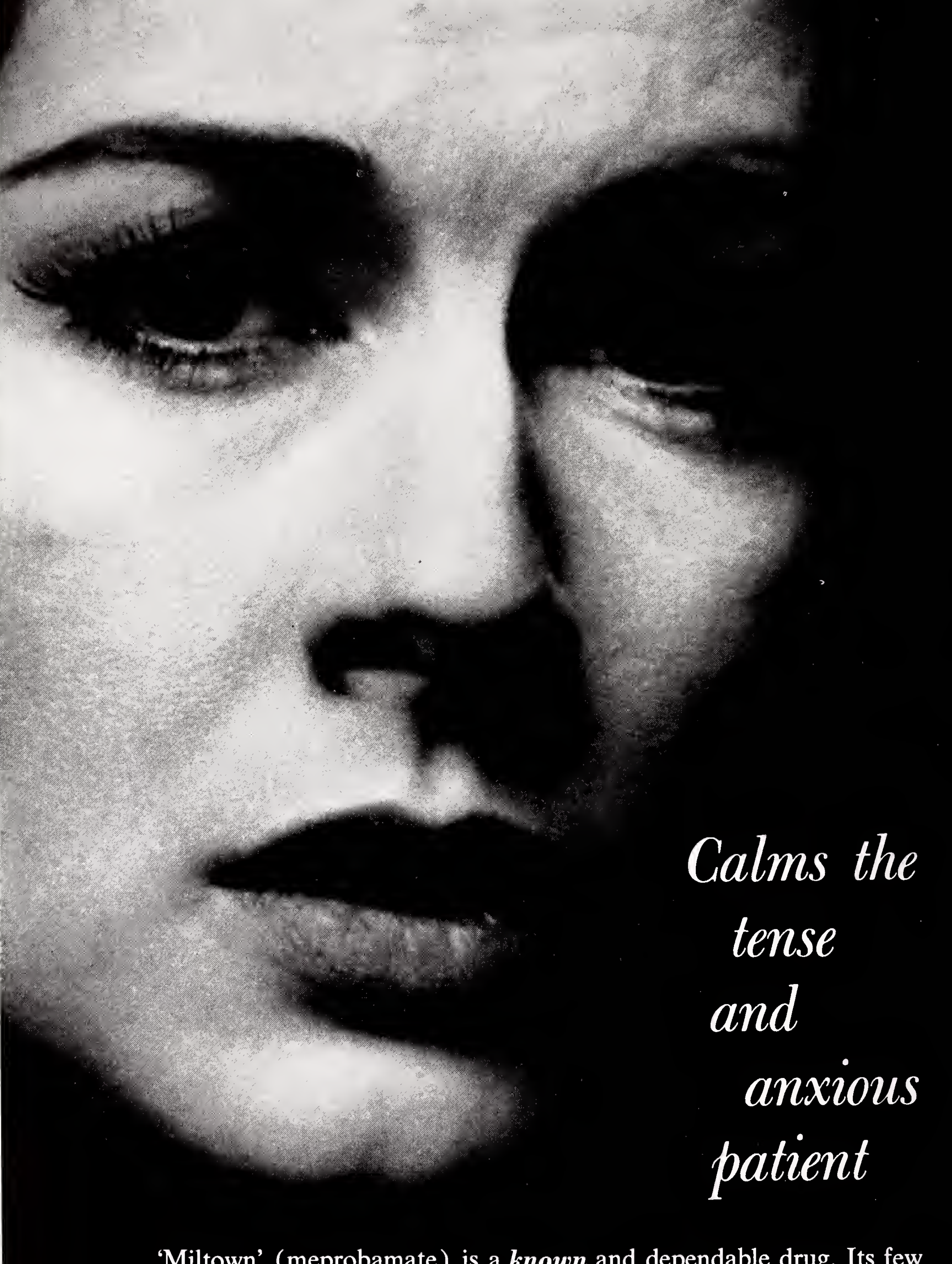

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U.S. Funds To Help Finance Rehabilitation Center

The United States government will provide $832,000 in Hill-Burton funds to help finance the building of a $1,300,000 Rehabilitation Center between Jewish and General Hospitals in the Louisville Medical Center, it was announced recently.

The remaining $468,000 is already available in cash and pledges, the result of a fund-raising drive held last year in Louisville. Bids will be opened about August 1 and construction will begin as soon as possible thereafter. It is hoped that the center will be open for patients next spring.

Asa Barnes, M.D., chairman of the Rehabilitation Center building committee, said the center will be the most complete facility for rehabilitation treatment in the area.

Herman Wing, M.D., will be the director of the new center. Doctor Wing is now the head of the present center. He is also chairman of the department of physical medicine at the University of Louisville School of Medicine.

Faculty Changes

The University of Louisville has announced the resignations from the General Hospital staff of Ronald C. Almgren, M.D., instructor in pediatrics, and Wyant Shively, M.D., instructor in pathology. Allan Lansing, M.D., has been appointed as associate professor in surgery.

Charles Blankenship, M.D., chairman of the department of community health at U. of L., has been granted a leave of absence for the summer for a study of the teaching of preventive medicine and public health in England and other European countries.

Additional Appointments

The following U. of L. staff changes have recently been approved: Appointments—Miss Breen Ratterman, instructor in anatomy; John Allen Yankeelov, Jr., Ph.D., assistant professor of biochemistry; Eugene H. Conner, M.D., chairman of the newly created department of anesthesiology (formerly a section); Donald T. Varga, M.D., and Nestor J. Carlisky, M.D., instructors in medicine; William H. Marshall, M.D., associate director of the Commonwealth Study to continue revision of the Medical School curriculum; William M. Lees, M.D., Ph.D., associate professor of surgery; Berel Lee Abrams, M.D., instructor in surgery; Nettie G. King, M.D., instructor in radiology, and Thomas Edward Campbell, M.D., instructor in ophthalmology.

Promotions—Charles E. Wagner, Ph.D., to associate professor of anatomy; Wesley Brown, Ph.D., associate professor of biochemistry; Marion F. Beard, M.D., professor of medicine; Laman A. Gray, M.D., to professor of obstetrics and gynecology; Harold W. Baker, M.D., associate professor of obstetrics and gynecology; Clinton Ray Potts, M.D., assistant professor of obstetrics and gynecology; Kee-chang Huang, M.D., to professor of pharmacology; Thomas G. Scharff, Ph.D., to associate professor of pharmacology; and William McDaniel Ewing, M.D., to associate professor of orthopaedic surgery.

Resignations—Jay Y. Gillenwater, M.D., instructor in medicine; Ronald C. Almgren, M.D., instructor in pediatrics; and Richard C. McPherson, M.D., instructor in surgery.

Doctor Wheeler Named Head Of Pediatrics At U.K.

Warren E. Wheeler, M.D., was appointed professor and chairman of the department of pediatrics at the University of Kentucky College of Medicine recently, replacing John H. Githens, M.D., whose resignation became final in June.

Doctor Wheeler

Doctor Wheeler has previously served as a consultant in pediatrics for the Michigan Department of Health, and as assistant medical director of Children's Hospital in Detroit. He most recently held the post of professor of pediatrics and microbiology at Ohio State University in Columbus, Ohio. He is a graduate of Mt. Union College and Harvard Medical School. His appointment at the University of Kentucky will be effective July 1, 1963.

Marion A. Carnes, M.D., was appointed recently as a professor in the department of anesthesiology. Doctor Carnes is a graduate of the University of Texas and of the University of Tennessee School of Medicine.

Other appointments at U.K. are: David C. Clemans, M.D., as instructor, department of anesthesiology; Gordon L. Hyde, M.D., instructor of clinical surgery; and Sylvester A. Shaffer, M.D., assistant professor of clinical community medicine.

Pediatric Society Elects

Keith M. Coverdale, M.D., Bowling Green, was elected president of the Kentucky Pediatric Society at the 13th annual meeting of the Society held in Lexington recently. Earl Williams, M.D., also of Bowling Green, was elected secretary-treasurer and Guy Cunningham, M.D., Ashland, was named vice-president.

At the same meeting the society established the "Richard Gill Elliott Memorial Award" in honor of the late Lexington pediatrician. A $250 prize is to be awarded annually for the best paper on a pediatric subject by a house physician in training in a Kentucky hospital.

John Lewis Duhring, M.D., Lexington, has begun the practice of obstetrics and gynecology in association with **John W. Green, Jr., M.D.** Doctor Duhring is a 1959 graduate of the University of Pennsylvania Medical School and served both internship and residency at the Hospital of the University of Pa.

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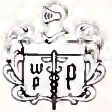

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Student AMA

U.K. Chapter Aims For Broader Outlook

During a recent meeting of the officers of the University of Kentucky chapter of the Student American Medical Association, held to discusss the goals of the organization for the coming year, we discussed our general feelings that medical education is neglectful in supplying to students information about activities outside of pure medicine.

Those "outside" areas include the fields of economics, politics and citizenship.

It was felt that the medical student by virtue of all his past training is ignorant of his role in these spheres. Yet all are aware of the importance these "extrinsic interests" will hold once the practice of medicine is begun. Incompetent planning and management could, we assumed, rock precariously an otherwise healthy practice.

Organizations clamor for capable leaders, but how much time should a physician take from his practice to participate in such activities? What is the physician's role in politics? It is rumored that doctors are part of the uninformed citizenry. Is an active citizen a good physician, or is a good physician a poor citizen?

It was not our contention that this should be part of the formal curriculum. We felt that student organizations such as our own could fill this need and our responsibilities could best be discharged by channeling our efforts in this area.

Toward this end, we plan to invite a variety of speakers to our programs next year, for talks on economics, legislation and other areas of interest. Too, we would like advice from members of KSMA as to other means of realizing our goals.

Ballard Wright
President

Open Letter to Kentucky Physicians, Patients

Dear Doctor:

Most doctors are agreed that the ileostomy patient's most crucial hurdle is that of adjusting to the wearing of a proper appliance. In spite of adequate medical and surgical care, ileostomy patients frequently have almost insurmountable problems with their appliances, and some of these problems are quite beyond the realm of the physician.

The accumulated experience and care of ileostomy patients suggests that there are two approaches for helping patients. One is help through mutual association organizations such as ileostomy clubs and two, guidance and consultation from trained therapists.

The Louisville area is fortunate in that a trained ileostomy appliance therapist is available for consultation. In addition, she is most interested in the formation of an ileostomy club whereby new appliance techniques and management of ileostomy problems can be reviewed at regular intervals.

All doctors whose patients might be interested in this type of endeavor are urged to have them contact Mrs. Anita Kotheimer, Medical Towers Building, Louisville 2, Ky., or telephone 585-2139. The formation of an ileostomy club seems a most worthwhile undertaking, and we recommend that all interested patients or doctors attend the meetings.

Very truly yours,
David W. Kinnaird, M.D.
Walter Hume, Jr., M.D.
Harold F. Berg, M.D.
Advisory Committee

Kentucky Addicts

(Continued from Page 577)

natural history of addiction, and produce at least some new hypotheses about the factors which are associated with relapse or continued abstinence. The early findings suggest a higher rate of abstinence, at least in non-metropolitan areas, than expected. These findings, if confirmed, may serve as a basis for a more hopeful attitude about the treatment of addicts.

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KSMA Council and Committee Reports

General Practice Committee

Homer B. Martin, M.D., Chairman

Kentucky Hotel, Louisville **May 9**

At its first meeting of the associational year, the General Practice Committee had as its guests representatives of the University of Louisville School of Medicine, the University of Kentucky Medical Center, and the University of Iowa School of Medicine.

The representatives of the medical schools discussed general practice teaching programs at their respective institutions. The committee then held a lengthy discussion on the crucial shortage of general physicians and the urgent need to create a suitable training program.

Observations made by the committee included that the present training period for general practice is too short, the plan for postgraduate residency should be flexible and adjusted both to the student and his geographic locale, and that Kentucky's schools are beginning to make the bold, imaginative steps necessary to restore general practice. The chairman noted that these and other observations will be amplified in the committee's report.

Insurance Committee

John Dickinson, M.D., Chairman

KSMA Headquarters, Louisville **April 18**

At the last meeting of the Insurance Committee, a number of complaints from insurance companies were reviewed and acted upon.

The chairman announced at the committee meeting that over 20,000 of the Health Insurance Council "short form" insurance forms had been distributed to KSMA members since approval of the forms by the House of Delegates in September, 1962. The Insurance Committee urged that more physicians adopt the use of these standard forms which are available from the Headquarters Office.

Lillian H. South, M.D., retired Louisville physician, was elected a member of the Royal Society of Health, founded in England in 1876, it was announced recently. Doctor South, a 1904 graduate of the Women's Medical College of Pennsylvania, is the only woman ever to have held an office in the American Medical Association. She was an AMA vice-president several years ago.

John W. Scott, M.D., Lexington, was honored at Centre College's alumni banquet during the annual weekend program held in Danville in April. Doctor Scott, 88, graduated from Centre 70 years ago, in 1893. In 1954 he was awarded the distinguished service medal by the Kentucky State Medical Association, of which he was president in 1939. Doctor Scott is an 1896 graduate of the Columbia University Medical Department.

Aging Committee

Earl P. Oliver, M.D., Chairman

KSMA Headquarters, Louisville **April 25**

KSMA Committee on Aging expressed its approval of the "AMA Eight Point Program for the Aged" at its recent meeting. The committee also made known its appreciation in the way that the Kerr-Mills Program has been administered in Kentucky and expressed its pleasure in Governor Combs' interest in construction of low cost housing for the aged.

Members of the committee approved a recommendation of sending a booklet entitled "A New Concept of Aging," to all Kentucky senior citizens groups along with a letter signed by KSMA President David M. Cox, M.D.

A number of recommendations were submitted by the committee to the Council on Medical Services in addition to the statement that, "In keeping with American traditions, the average American citizen is able and willing and furthermore wishes to provide for his own medical care and other needs through voluntary facilities, and does not wish to become a ward of the State. Further, that those who are actually not able to provide for their own needs, through no fault of their own, can adequately be cared for on a local level through Kerr-Mills Programs."

Tuberculosis Committee

Shelby Hicks, M.D., Chairman

Louisville **May 16**

The Tuberculosis Committee has held its first meeting of the associational year and had as its guests M. Stewart Lauder, M.D., Director, Tuberculosis Division, State Department of Health.

The committee discussed in detail the tuberculosis program in Kentucky and recommended that serious consideration be given to including an educational program on case detection and early diagnosis of tuberculosis in continuing medical education programs.

The committee expressed its interest in seeing the state T.B. Coordinating Council re-activated and went on record in favor of continued state financial support to the Covington-Kenton County T.B. Hospital.

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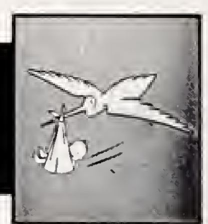

CASE #131 — The patient, a 32 year old divorced Negro gravida 7 para 6, was first seen near term at 9:00 p.m. on April 18, 1961, with the history of spontaneous rupture of the membranes since April 16, 1961.

Cesarean Section

On examination at this time, the fetus lay in transverse lie, and the umbilical cord was prolapsed. The blood pressure was 108/78, and the pulse, 96. The temperature was 100°. The fetal heart beat could be ausculted. A consultant advised immediate cesarean section. Under general anesthesia, a left paramedian incision was made. The uterovesical fold of peritoneum was incised horizontally and the uterus was opened longitudinally. The posterior arm of the fetus was prolapsed into the vagina. A living male infant requiring resuscitation was delivered at 1:55 p.m. The uterus was closed in two layers. A dermoid cyst measuring approximately 5 x 5 cm in the right ovary was removed. The patient left the operating room in excellent condition. The post-operative course was febrile in spite of large doses of penicillin, with temperatures fluctuating between 103° and 99°.

Patient Allowed Up

On April 20, 1961, she was allowed out of bed, even though her pulse was rapid (120), and fever persisted. On the morning of April 20, 1961, the patient was described as cold and clammy, and was noted to be perspiring freely. The blood pressure was 110/80. Wangensteen suction was attached, but the patient promptly pulled the Levine tube out; when reinserted, 700 cc of fluid was aspirated. At 11:00 p.m., the patient was still cold and clammy, and no blood pressure or pulse could be obtained. A vaso-pressor was injected, a cut down was performed and infusion of 5% dextrose in saline with 4 cc of Levophed added was started. The blood pressure failed to respond and the pulse which could now be felt, was rapid to count at 12:30 a.m. The patient died at 1:00 a.m. on April 21, 1961. No autopsy was performed. The cause of death listed on the certificate was: cerebral hemorrhage.

Comments

The Committee judged this case to be that of a direct obstetrical death and the cause of death as given on the certificate could not be ruled out. Nevertheless, the findings described in the protocol were considered equally suggestive of peritonitis as a likely cause of death. The relatively low fever in this critically ill patient may have indicated low host resistance to the infection. Preventable factors were present in this case, since if this patient had been seen prenatally when the membranes first ruptured and the transverse lie had been discovered, at that time abdominal delivery could have been performed before the infection occurred.

Under the clinical circumstances described at the time of admission in a 32 year old para 6, either a cesarean hysterectomy or an extraperitoneal section might have been preferable to the conservative transperitoneal operation.

In Memoriam

GEORGE A. ROBERTSON, M.D.
Louisville
1872-1963

George A. Robertson, M.D., 91, Louisville eye, ear, nose and throat specialist, died June 13 at St. Joseph infirmary. He retired in 1962 after 66 years in the practice of medicine in Loiusville. Doctor Robertson, a native of Burlington, Iowa, was a member of the faculty at the Medical Department of the University of Louisville from 1903 to 1908. He received his M.D. from U. of L. in 1896.

E. T. RUNYON, M.D.
Ewing
1875-1963

E. T. Runyon, M.D., 88, Ewing, died June 19 after 61 years of general practice in Madison and Fleming counties. Doctor Runyon, who retired only three months ago because of ill health, was graduated in 1902 from the Hospital College of Medicine in Louisville. He was a native of Fleming County.

I. M. GARRED, M.D.
Morehead
1905-1963

I. M. Garred, M.D., 57, Rowan County general practitioner for 33 years, died June 20 at St. Joseph Hospital in Lexington. Doctor Garred, a native of Louisa and a 1928 graduate of the University of Kentucky, received his M.D. degree from the Univeristy of Louisville College of Medicine in 1932.

JACK DICK, M.D.
Louisville
1915-1963

Jack Dick, M.D., 47, died on May 31 at St. Joseph Infirmary in Louisville. Doctor Dick had practiced industrial medicine at duPont de Nemours and Co. in Louisville for 14 years until he retired in 1961 because of ill health. He was a 1941 graduate of the Indiana University Medical School, and was a native of Huntington, Indiana.

DONALD W. ANDERSON, M.D.
(formerly) Madisonville
1915-1963

Donald W. Anderson, M.D., 48, former Madisonville, Ky. general practitioner, died May 4 in Frankfort, Ill., where he had practiced since 1961. He was a 1940 graduate of the University of Illinois College of Medicine.

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Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

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Answers To Questions About Your

BLUE SHIELD

(Q) Will you please tell me the difference in the cost of the Standard Blue Shield Plan, the Preferred Plan, Schedule C and Schedule D?

(A) Group Monthly Blue Shield Dues (With In-Hospital Medical Benefits starting on the 4th Day)

	Standard	Preferred	Schedule C	Schedule D
Single	$ 1.25	$ 1.70	$ 1.35	$ 1.80
Family	$ 2.50	$ 4.55	$ 3.65	$ 5.10

Non-Group Quarterly Blue Shield Dues (With In-Hospital Medical Benefits starting on the 4th Day)

	Standard	Preferred	Schedule C	Schedule D
Single	$ 4.50	$ 5.85	$ 4.80	$ 6.15
Family	$ 9.00	$15.15	$12.45	$16.80

(Rates are slightly higher for those members with In-Hospital Medical Benefits starting on the first day of hospitalization.)

(Q) Why don't all Blue Shield members have the same benefits?

(A) Blue Shield is a voluntary plan. Some members can afford to pay only for minimum benefits; some prefer to meet certain costs out-of-pocket instead of by prepayment. Others, through management-labor contracts, bargain for benefits or so many cents per hour. No one is compelled to become a member, and members have choice of a variety of benefits.

(Q) Are all present Blue Shield members required to change to Schedules C and D?

(A) No. All are being offered the opportunity, but Blue Shield is a *voluntary* plan, and those members or groups who desire to continue the Standard or Preferred Plans may do so.

(Q) Why are some of the allowances in Schedules C and D less than in the Standard and Preferred Schedules?

(A) A few allowances have been decreased in an effort to remove inequities that exist in the Standard and Preferred Schedules.

(Q) Why must the age of the patient now be given on Blue Shield Claim Forms?

(A) Due to the present interest in health costs nationally and in prepayment organizations, more information is needed by the A.M.A., A.H.A., and Blue Shield on utilization by age groups. Age is also becoming an important factor in determining trends in health care for actuarial purposes.

(Q) Does Blue Shield ever pay the maximum allowance for both the surgical removal and the x-ray therapy of cancer?

(A) Yes. On September 17, 1962, the Board of Directors of Blue Shield approved payment for both the surgical removal and x-ray therapy of cancer under Standard and Preferred Blue Shield Certificates. This also applies to Schedules C and D.

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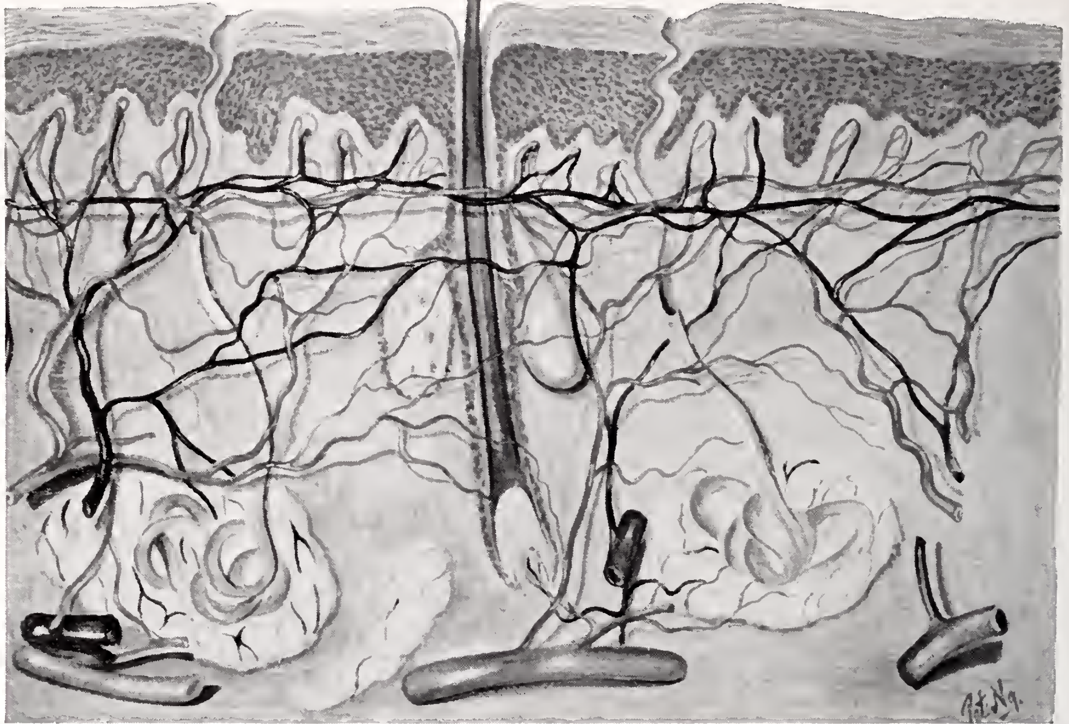

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WASHINGTON NEWS DIGEST

WASHINGTON, D. C.—Chairman Wilbur D. Mills (D., Ark.) of the House Ways and Means Committee has made clear that he still opposes the Kennedy Administration's legislation that would provide social security hospitalization for aged persons.

Mills said he did not intend to permit a social security bill he introduced to be used as a vehicle for Congressional action on any version of President Kennedy's disputed program.

The Mills bill would make the first $5,400 in annual earnings subject to the social security tax. It is $4,800 now. Kennedy's social security hospitalization bill would increase the tax base to $5,200.

The objective of the Mills bill is to strengthen the social security trust fund's financing by eliminating most of the long-range deficit now in prospect.

"My only intention in introducing the bill is to get the fund on an actuarially sound basis and to call attention to the fact that it is not actuarially sound now," Mills said.

"I assume everybody knows that I do not support the enactment of medicare under the social security program.

Another Democrat on the Ways and Means Committee. Rep. A. Sidney Herlong, Jr. of Florida, also expressed strong opposition recently to the Kennedy legislation, known as the King-Anderson bill, or any other plan to finance health care through social security.

This position by Mills and Herlong made it unlikely that the Ways and Means Committee, where such legislation normally is acted upon first in Congress, would approve any health care plan financed through social security.

However, supporters of the King-Anderson bill could try to attach it as a rider to another social security bill on the Senate floor. This was the maneuver they attempted—unsuccessfully—last year.

* * * * * *

The Senate has approved the Kennedy Administration's $848.5 million mental health bill by a vote of 72 to 1. Its sponsors were confident of House passage also.

The American Medical Association had testified in support of the legislation when it was before the Senate Labor and Public Welfare Committee.

The bill would provide:

—A four-year program, costing $230,000,000, under which Federal grants would go to states for construction of public or other nonprofit community mental health centers. Funds would be allocated on the basis of population and need.

—An eight-year program, costing $427,000,000, of Federal grants to states for staffing of these mental health centers. Federal aid would gradually decrease and eventually would be cut off.

—A five-year program, costing $30,000,000, of Federal grants to public or other nonprofit institutions for construction of research centers and facilities for the mentally retarded.

—A five-year program, costing $42,500,000, of Federal grants for constructing college or university facilities to offer services to the mentally retarded and training for persons dealing with the retarded.

—A four-year program, costing $67,500,000, of Federal grants to states for constructing facilities for the mentally retarded. Funds would be allocated on the basis of population and need.

—A three-year program, costing $45,500,000, for training of teachers of the mentally retarded, deaf, emotionally disturbed, crippled and other handicapped children.

—A three-year program of research and demontration projects in education of the handicapped.

* * * * * *

The National Cancer Institute says that research strongly suggests viruses cause cancers in humans.

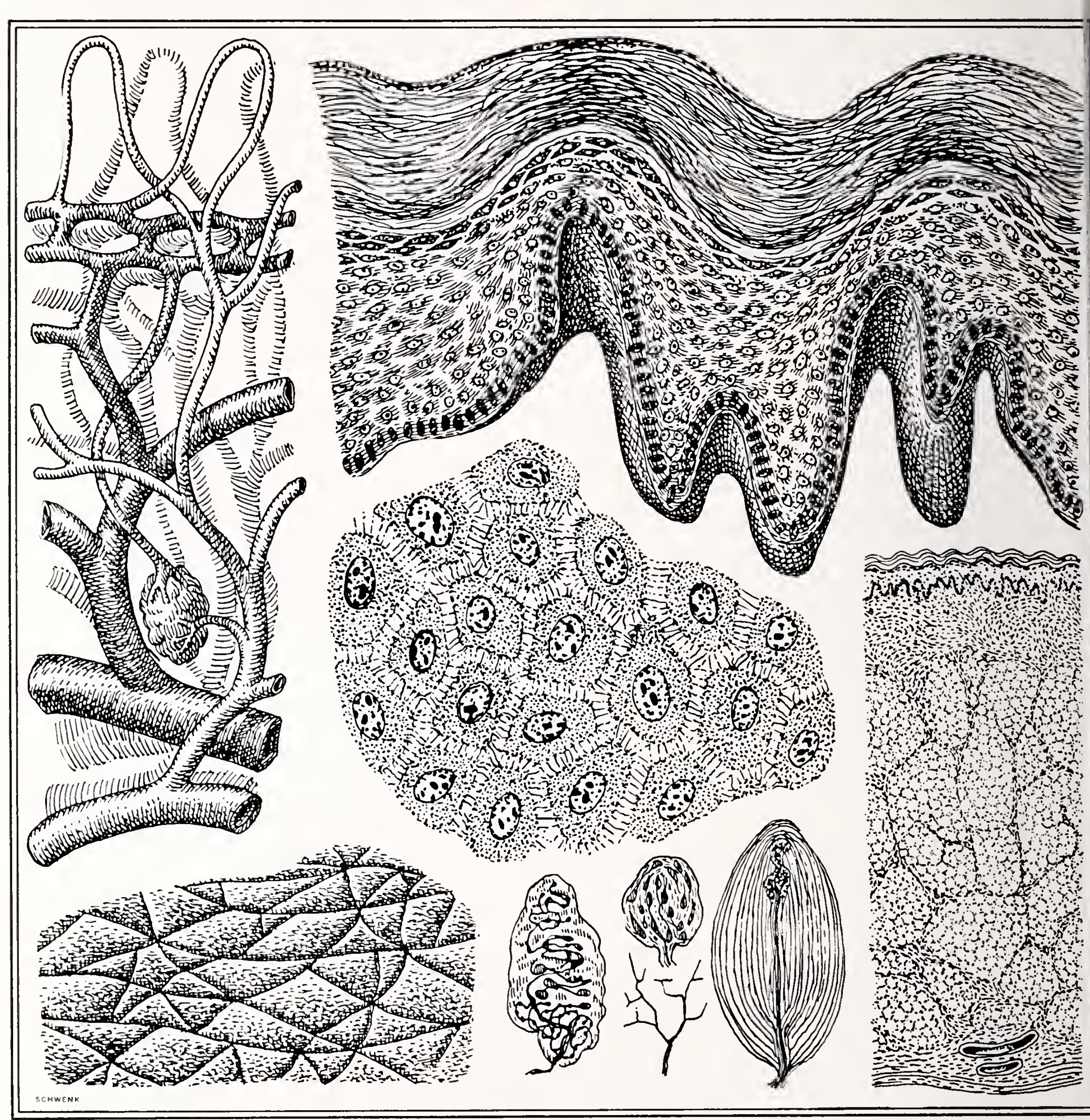
Reviewing medical research in the past year before a House budget subcommittee, a National Institute of Health official said:

"The scientific evidence accumulated over a number of years, and particularly in the last half-dozen years, has demonstrated that viruses cause many forms of cancer in animals under experimental conditions. . .

"The large volume of such evidence, coming from a wide variety of scientific disciplines, is so strongly suggestive of a virus-cancer relationship in man that the National Cancer Institute has given active encouragement to research in this area. To date, no human cancer-causing virus has been found. However, we know for example of a group of human viruses that have not yet been linked with specific disease, and some animal viruses that cause bizarre changes in human cells growing in tissue culture. . .

"The present state of knowledge leaves no doubt in our minds that viruses must be studied not only as a single possible cause of cancer in man, but in the whole context of carcinogenesis. The possible interaction of substances in the total environment—such as radiation, chemicals, and viruses—in giving rise to cancer in the population must be taken into account. Already there is laboratory evidence that this can occur in animals."

Dr. Kenneth M. Endicott, Director of the National Cancer Institute, told the subcommittee that "there is no doubt left in my mind that there is very strong association between excessive smoking and high incidence of cancer of the lung."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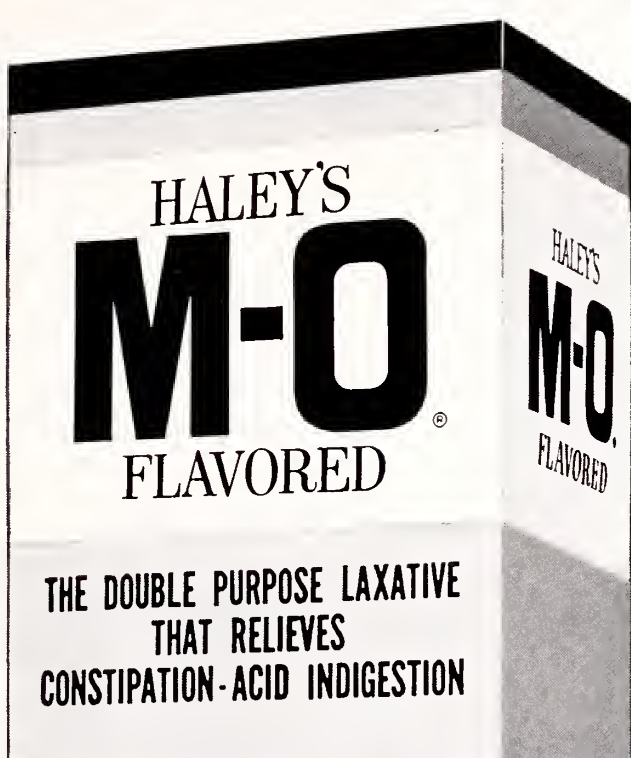

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J. VERNON PACE, 333 Broadway, Paducah .... Jan. 1, 1962-Dec. 31, 1963
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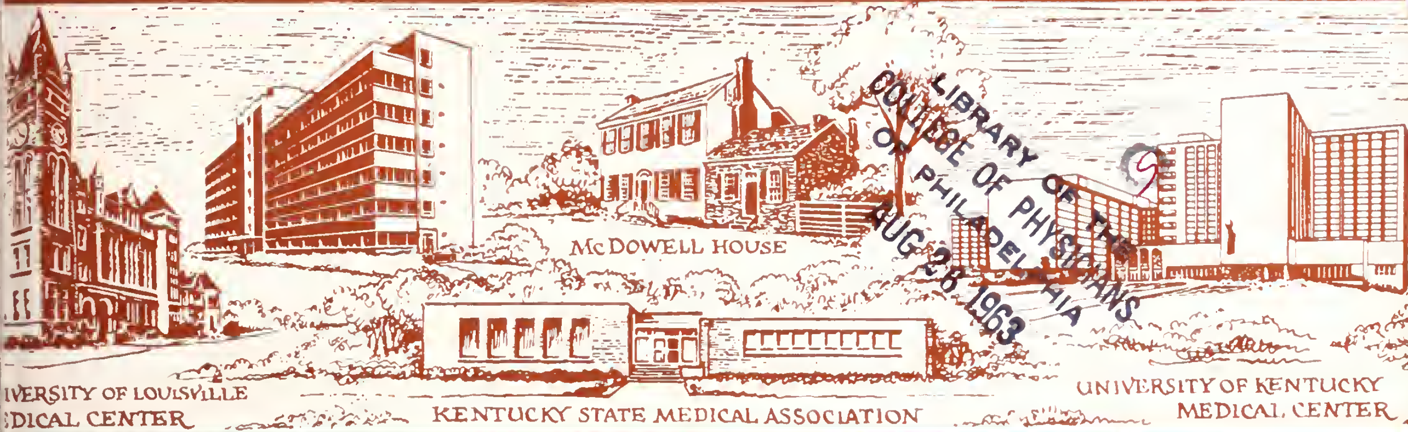
Annual Meeting Issue

(pages 674 - 698)

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION



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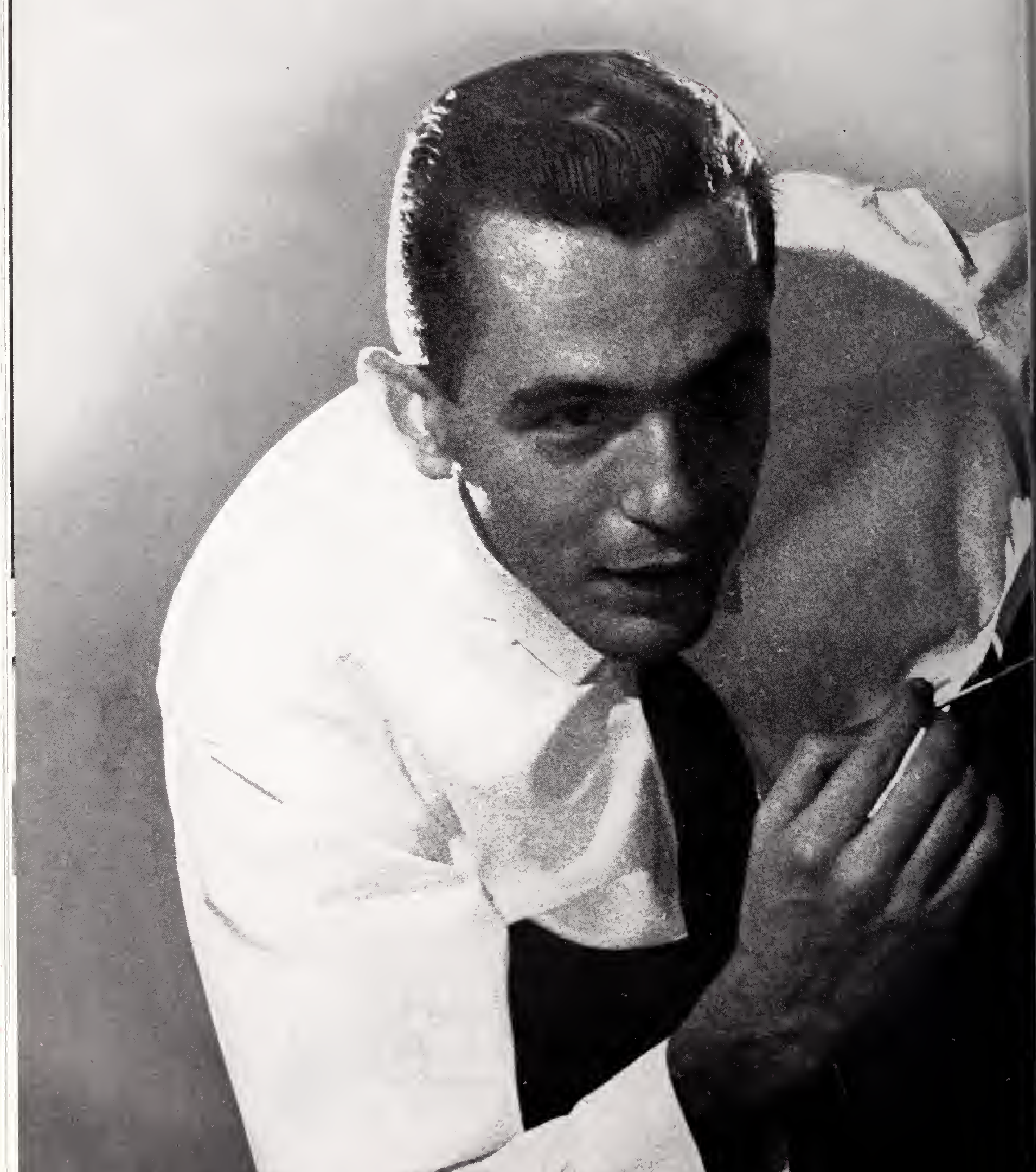

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REFERENCES: (1) Hammill, J. F.: J. Chron. Dis. 8:448, 1958. (2) Roseman, E.: Neurology 11:912, 1961. (3) Bray, P. F.: Pediatrics 23:151, 1959. (4) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (5) Crawley, J. W.: M. Clin. North America 42:317, 1958. (6) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (7) Ibid.: Postgrad. Med. 20:584, 1956. (8) Merritt, H. H.: Brit. M. J. 1:666, 1958. (9) Carter, C. H.: Arch. Neurol & Psychiat. 79:136, 1958. (10) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (11) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.

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MESSAGE FROM THE PRESIDENT

Autocracy

AS WE READ the newspaper headlines in a troubled world, as we observe the tides of discontent, and as we search for an alibi, we discover that unhappiness on earth is man-made. Our key weakness is that we have not solved the problem of self-government. Whether it be in areas of large population or small countries, or even the United States, the quest for national contentment is plagued by friction, disorder, and violence.

Many approve of an all-powerful autocratic state in which Government arbitrarily and inequitably dictates the amount of income a citizen may retain, or the kind of business in which he may engage, or the customers he may serve, or the number of employees of each race or religion or other classification he may employ.

We seem reluctant to accept the fact that all human beings are not alike and that intelligence cannot be bestowed by Government.

We observe within our country today harassments by Government that tend to dull the initiative of our successful and competent citizens and thus destroy the private enterprise system, which has been superseded by the "public" enterprise system. The mob, encouraged by Government, stands at the threshold of our legislative halls demanding such laws.

Is this the road to happiness? There can never be human happiness in a society that imposes a rule of "equality" which disregards merit and rewards incompetence. This is the road that leads to the disasters that befell autocracies in the past. The Government can do nothing as efficiently as private enterprise.

The happiest people are those who have sought and found how to serve. Service to our fellow man is the rent we pay for the space we occupy on this earth.

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THE INSURANCE PAGE

Voluntary Health Prepayment Continues To Grow

IN spite of the enthusiastic acceptance by the American people of voluntary prepayment mechanisms for providing health care, there are still many proponents of the Welfare State who insist that our voluntary health coverage is inadequate, and claim that our people would have more satisfactory health care under a governmental system, such as most European countries maintain.

Statistics do not support their contention that the voluntary system is doing a poor job of providing health care in this country.

Recent figures released by the Health Insurance Institute revealed that at the end of 1962, seventy-six percent of our civilian population had some type of health insurance coverage. During the year, the number of persons covered increased by four and a half million. Including benefits for loss of income, more than seven billion dollars were paid out last year for health insurance benefits.

Hospital expense insurance was provided to 85,174,000, by insurance companies, and to more than 60,000,000 by Blue Cross and similar groups. Other health care plans gave hospital expense coverage to nearly 7,000,000 people. Even after deducting for persons covered by more than one type of insurance, the Health Insurance Council estimated that more than 141,000,000 persons in this country have hospital insurance.

Surgical expense insurance covered 131,000,000 persons. More than 98,000,000 had regular medical expense coverage (a 4.2 percent increase over 1961). Major medical expense coverage, which is designed to help absorb the costs of serious illness, was provided to 38,250,000 persons. Loss of income insurance was estimated to cover 33,600,000 individuals.

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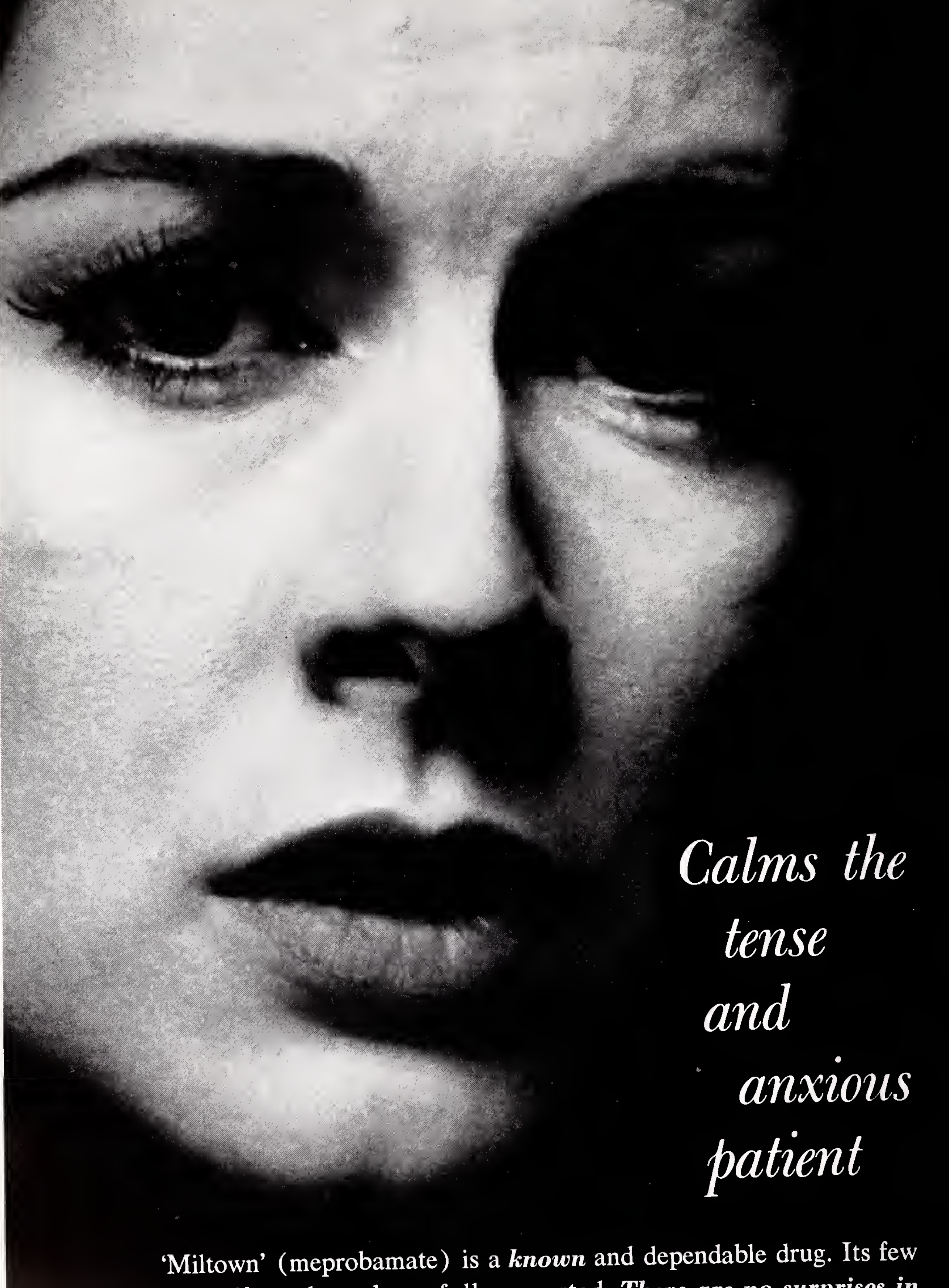

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PUBLIC HEALTH PAGE

Food Borne Diseases*

Russell E. Teague, M.D., M.P.H.
Commissioner of Health *Commonwealth of Kentucky*

RECENT highly publicized outbreaks of food-borne illness, both in Kentucky and elsewhere, have served to emphasize the importance of immediate, well-coordinated investigation of such incidents. Although epidemics of food-borne disease can occur at any time of year, a regular peak in seasonal incidence appears during the summer. This is probably the result of general changes in food preferences and eating habits coupled with greater opportunities for contamination and prolonged exposure of foods to effective incubation temperatures. In any event, the subject of food-borne diseases is a timely one.

For purposes of this discussion a food-borne disease is defined as one in which the causative agent reaches the host through a vehicle which is ingested. Such vehicles include all foods, milk, water, and other beverages. A variety of illnesses may result from consumption of items contaminated with pathogenic microorganisms (salmonella, streptococci, shigella, *Escherichia coli, Trichinella spiralis,* infectious hepatitis virus, etc.), toxic products of microorganisms (staphylococcal enterotoxin, the toxins of *Clostridium botulinum* and *C. welchii,* etc.), chemicals (antimony, arsenic, cyanide, flouride, lead, etc.), or poisonous plants and animals inadvertently mistaken for or included in edible items (certain species of mushrooms, shellfish containing the plankton, *Gonyaulax,* etc.).

It is generally agreed that food-borne diseases are one of the most common forms of illness occurring in the United States. However, due to lack of reporting and adequate epidemiologic followup of cases the actual incidence of food-borne disease in the U.S. is not known. Estimates of more than 1 million cases per year are made by many authorities in the field. Most mild cases never come to the attention of the practicing physician and, therefore, cannot be reported. On the other hand, the physician tends not to associate an individual case of, say, gastroenteritis with an actual outbreak of food-borne disease and, therefore, does not notify the health department. Consequently figures based on reported incidence are grossly inaccurate and misleading.

The chief purpose for the investigation of a food-borne disease outbreak is the determination of all the circumstances which lead up to the incident and the application of the derived knowledge toward the immediate control of the epidemic and the prevention of similar occurrences. A more effective over-all sanitation program for the food industry and the consuming public is the ultimate goal.

Delays in reporting and investigating possible food-borne disease outbreaks obviously impair the quality and quantity of the derived information. Standard investigative procedure usually entails the immediate quarantine and sampling of left-over foods from the suspect meal, collection of food histories and other information on all persons (both ill and not ill) who consumed all or any portion of the meal, complete inspection of the premises where the foods were prepared and/or served, tabulation and statistical analysis of the collected information, and performance of the indicated laboratory procedures on foods epidemiologically implicated by the investigation as well as clinical specimens collected from the victims themselves. Since most practicing physicians do not have at their disposal the time or the trained assistants necessary to perform such an investigation, official health agency personnel usually assume this responsibility.

The Kentucky State Department of Health committee on food-borne diseases is composed of representatives of all disciplines having interest and training in the investigation of food-borne disease outbreaks. The committee serves as a consultant group to all local health departments in Kentucky on investigative technics, and lends direct assistance where such is indicated.

A kit of materials (case history questionnaires, forms, food sampling devices and containers, etc.) useful in the investigation of food-borne outbreaks has been designed by the committee for distribution to each county health department in the State. Training sessions for local health department personnel have been conducted and are being planned for the future.

The practicing physician can, therefore, rely on the local health department in his area to be fully acquainted with the investigative technics useful in food-borne disease outbreaks. He should immediately report all incidents of suspected food-borne illness so a thorough investigation can be performed, and a widespread epidemic or recurrence of similar episodes can possibly be averted.

**This article was prepared by: J. W. Skaggs, D.V.M., M.P.H., Prin. Veterinarian, Zoonoses Control, Kentucky State Department of Health, 275 East Main St., Frankfort, Ky.*

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REFERENCES: **1.** Barden, F.W., Hill, P.S., Mahaney, W.F., and Cuneo, K.J.: J. Maine M.A. 45:11, 1954. **2.** Chaput, Y., and Baillargeon, J.: L'Union med. du Can. 86:205, 1957. **3.** Hock, C.W.: Clin. Med. 8:1932, 1961. **4.** Kilstein, R.I.: Rev. Gastroenterol. 14:171, 1947. **5.** Marks, L.: Am. J. Gastroenterol. 27:180, 1957. **6.** Wharton, G.K., Balfour, D.C., Jr., and Osmon, K.L.: Postgrad. Med. 21:406, 1957.

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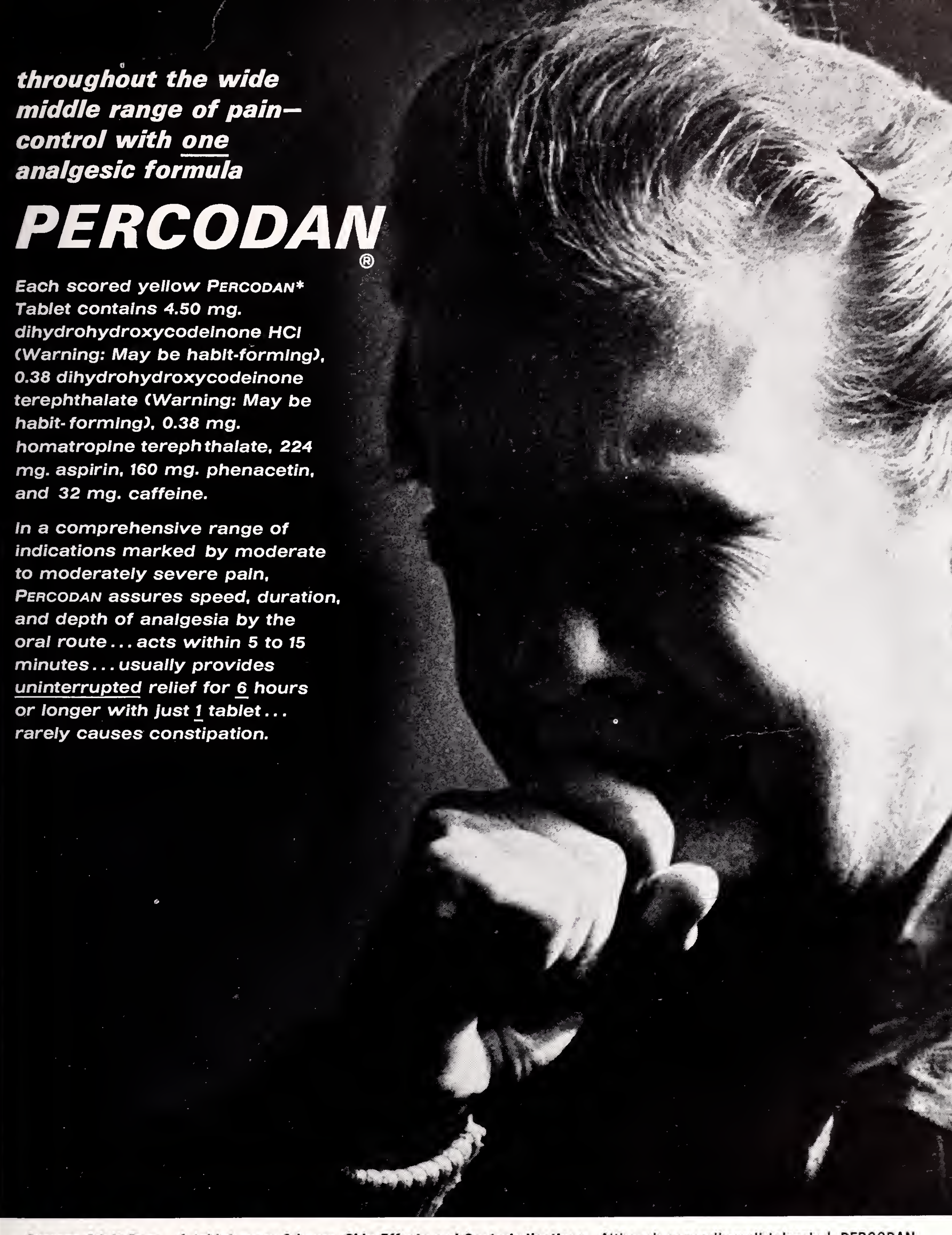

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Current Status of Combined Surgery and Chemotherapy in the Treatment of Cancer†*

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Lexington, Ky.

A summary of the current therapy and future plans in the chemotherapy of solid tumors in preventing spread of tumors at operation, in reducing postoperative recurrence, and in reducing tumor size prior to operation.

IN THE LATE 1940's and early 1950's the gradual trend towards increasingly larger operations for cancer came to a halt. The presumption that bigger and bigger operations for tumors would necessarily result in larger and larger survival rates was shown in error. For some time thereafter it appeared that little progress could be anticipated in the surgical treatment of cancer, yet today this field of endeavor is again in ferment. This has come about through the combination of excisional surgery with various methods of chemotherapy. This is still a very young field and there are still many more questions than answers available. My object is to examine some of these questions and evaluate the answers we have.

A combination of chemotherapy with operation in the treatment of malignant tumors is directed to three possible goals: 1. To prevent local recurrence; 2. To prevent distant spread; and 3, To aid in removing gross tumors. Chemotherapeutic agents may be used to satisfy one, both, or all of these aims. Through long association with the use of chemotherapy in the preterminal cancer patient many have come to relate the use of these agents to palliation and yet, proven sufficiently reliable to depended most often that is still their most useful role. However, it is refreshing to realize that in combining chemotherapy with operation the object is to improve survival, not simply to obtain palliation. In their new role these drugs are used in patients who have localized tumors and who may be regular candidates for operative therapy.

The concern with the prevention of local recurrence and of distant metastases at the time of definitive operation is a direct result of the accumulating evidence of the past several years which indicates that a substantial percentage of patients after operation have viable tumor cells littering the operative field.[3] It is also becoming apparent that many tumors begin to seed the blood stream long before diagnosis.[4, 7, 10] This "canceremia" can be correlated in some degree with the patient's eventual outcome. It is also realized that the presence of cancer cells in the blood stream does not necessarily doom the patient, for most of these cells are destroyed by the body's natural defenses and only a few survive and implant to develop later as metastases. The occurrence of metastases is probably re-

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lated directly to the concentration of the cells in the blood and to their degree of viability.

It has been suspected for many years that vigorous manipulation of a tumor seeds the blood stream and the lymphatic circulation with additional tumor cells. Recent research has confirmed this.[7] Thus it is likely that irrigation of the wound with tumorcidal agents at the time of operation will diminish the tendency towards local recurrence. It is also likely that intravenous therapy with such agents during operation and for a short period thereafter will reduce the viability of cancer cells in the circulation, thus decreasing the chance of metastasis.

Local Chemotherapy

Let us consider each of the possible uses for chemotherapy combined with operation. Since we know that the wound is frequently contaminated with cancer cells after excision of a tumor the most obvious attack would be to wash the wound with an agent which is lethal to these cells. Such local application of tumorcidal agents has a long and not entirely respectable history. Hippocrates recorded the use of caustics in the treatment of superficial tumors in the 5th Century B.C. In the intervening centuries many quack practitioners and some honest ones also used caustic pastes in treatment of some skin tumors.

It is interesting to note that as early as 1931, stimulated by the suggestions of James Ewing, then the director of the Memorial Center for Cancer, Adair and Bagg attempted the treatment of external malignant lesions in humans with the superficial application of mustard gas dissolved in water.[1] They reported excellent regression in a number of lesions, but the experiments were discontinued promptly when one of the investigators contracted pneumonia from the inhalation of mustard gas.

As to the specific application of chemotherapeutic agents to a wound after operation there seems to be abundant experimental evidence that this should be of value. Animal studies suggest that the most potent agents in this regard are the alkylating agents such as nitrogen mustard and related analogs. Distilled water, chlorpactin, and simple mechanical irrigation with saline have also been investigated but have less effect. A modest clinical literature has accumulated relating to the local effect of alkylating agents and other compounds, but no definite conclusions can be drawn so far. This is largely due to the fact that use of local irrigation has been superseded by the use of systemic chemotherapeutics during and at the end of operations. To many this seems the more logical approach since local chemotherapy affects only the area of the wound while systemic chemotherapy affects both the local area and circulating tumor cells.

Systemic Chemotherapy

This brings us to a consideration of the application of systemic therapy as an adjuvant to cancer surgery. Study of this subject has been intense. It can be claimed with some pride that some of the best controlled clinical work ever done is being accomplished in this field. Stemming from the studies organized under the auspices of the National Chemotherapy Service Center and initiated in 1957, evaluations were carried out on the systemic use of chemotherapeutic drugs during and following operations in carcinoma of the lung, colon, breast,

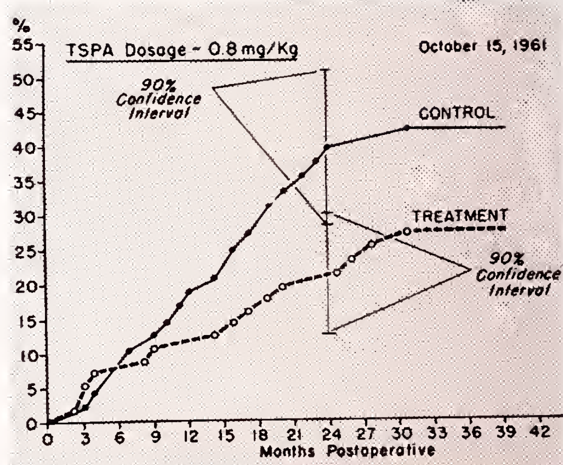

Figure 1. Significant difference in local and distant recurrence of carcinoma following radical mastectomy in patients treated with Thiotepa at operation versus patients untreated with chemotherapy. (From Noer, R., Cancer Chemotherapy Reports 16:137, 1962. By permission).

stomach and ovary. The chief agents used were nitrogen mustard and its analogs. When these studies started these drugs were the most potent agents at hand. The results of the first round of studies are now in and it is evident that such operations can be done in combination with chemotherapy without undue hazard to the patient. The most promising study of those mentioned was that carried out under the co-

ordination and direction of Noer. This study, done in many institutions about the country, indicated that there was a definite decrease in the rate of local recurrence and distant metastases following operation in patients treated by radical mastectomy for carcinoma of the breast when such patients were given adjuvant therapy with Thiotepa (Fig. 1). Further studies indicate that the major benefit has been in premenopausal women with axillary involvement. Results with adjuvant therapy in tumors of other sites were much less clear-cut. These studies are now going into their second round, applying new agents which appear to have much more specificity for the tumors involved.

The Agents

Now let us consider the agents used for combating tumors today. One frequently hears the complaint that the trouble with chemotherapy is that "we just don't have drugs which are powerful enough." This is in a large sense true, but a few years ago one spoke of chemotherapy only in terms of its effect on lymphomas and leukemias. It was generally agreed that the effect of these agents on solid tumors was negligible and hardly worth studying. Yet today we are seeing more and more articles describing the effective shrinkage, or even occasional disappearance of epidermoid carcinomas and adenocarcinomas treated with chemotherapy. This change has been brought about by new techniques and new agents which are more specific for solid tumors.

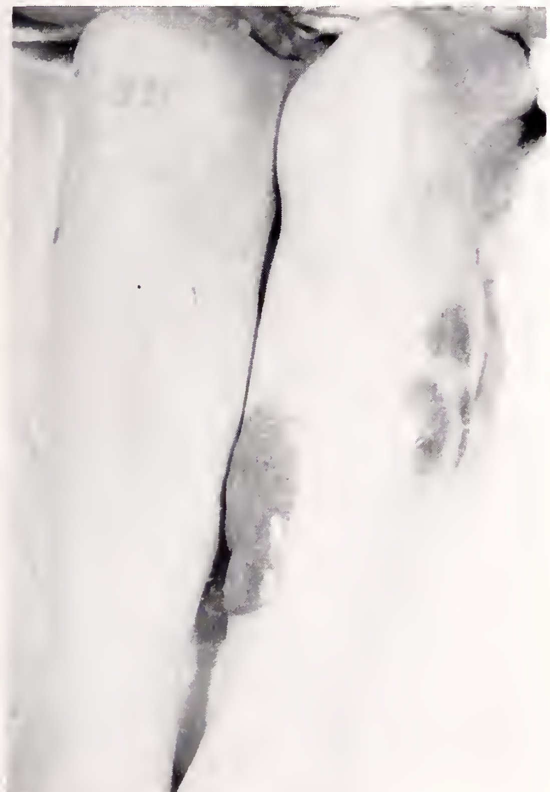

Figure 2. An 80-year-old white female with amelanotic melanoma metastatic to the legs from an unknown primary.

Perhaps the most prominent new agent in the treatment of solid tumors has been 5-Fluro-uracil. This is an antimetabolite. The recognition of its value arose from the excellent work of Currari at Wisconsin who demonstrated that 5-FU given intravenously was effective in causing temporary or complete regression in 40% of patients with disseminated carcinoma of the breast, and in 25% of patients with carcinomas of the rectum and colon.[2] These results were initially doubted since they indicated such a new direction in the effectiveness of chemotherapy, but have now been repeatedly confirmed. This year the National Chemotheraapy Service Center introduces 24 promising drugs into trial. Many, perhaps most, of these will prove no better than our current drugs, but as these trials progress we can hope that one, or some of them, may hold additional pleasant surprises for us as did 5-FU.

New Techniques

Turning from new agents to new techniques, the two most promising have been the methods of isolated regional perfusion suggested by Klopp et al[6] and developed by Creech and Kremitz[5] and the use of regional arterial infusion originally used by Klopp and developed and expanded by Sullivan.[9] Isolated regional therapy after its initial evaluation appears likely to be most useful in treating lesions of the extremities (Figs. 2 & 3). It is worth noting that one of the first patients treated by Creech and his group had a disseminated melanoma which was limited to one extremity. This patient is now five years post treatment without evidence of recurrence.

Arterial infusion is a newer approach and when combined with 5-FU in the treatment of head and neck tumors it has brought promising regressions in some patients. Tarr[10] in Baltimore, and Stehlin[8] in Houston have reported complete regression in some lesions which have remained without recurrence for as long as two years. The most appealing aspect of this tech-

nique is its simplicity.

Finally we come to the third possible use of chemotherapy as an operative adjuvant. That is its use in reducing the bulk of tumor prior to the operation chiefly in the hope of restricting the scope of operation necessary, such as substituting a local excision for amputation. Stehlin[8] has reported the successful use of such an approach in a few patients; however, follow-up data is as yet limited.

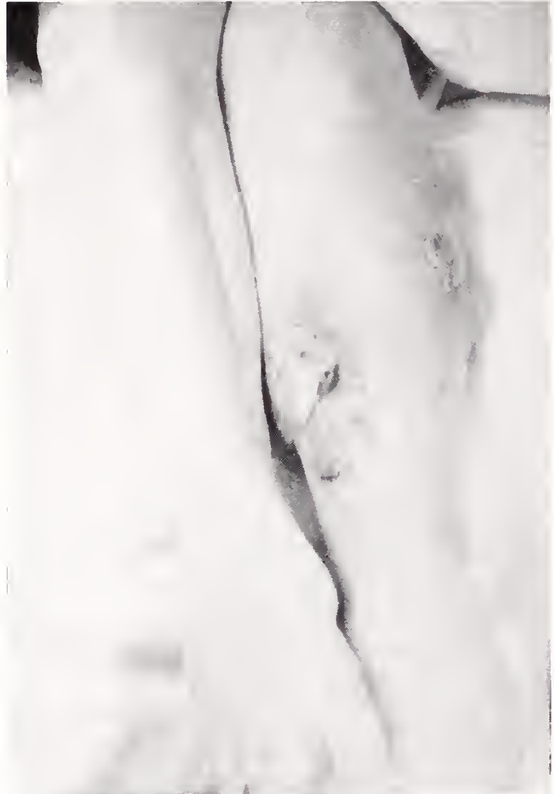

Figure 3. Same patient six days following isolated arterial perfusion of the extremity with Thiotepa. Even at this short period the lesion shows rapid resolution.

As stated earlier, this is a young field. From the various facets touched on it is obvious that combinations and permutations of the agents available and of the new techniques are endless and will provide a source for systematic and continuous investigation for some time to come. Still, at the outset of this journey the potential seems great, the prospects are bright, and the prize to be gained most precious both to the surgical patient and to the surgeon.

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Carotid, Vertebral and Direct Non-Catheter Brachial Cerebral Angiography with Meglumine Iothalamate 60%

T. R. Marshall, M.D.,* J. T. Ling, M.D.,** and R. Gonzalez, M.D.***
Louisville, Ky.

A new method of cerebral angiography by direct non-catheter right and left brachial artery injection is discussed. Visualization of the entire cerebral circulation is obtained.

THERE is a continuous search for the ideal contrast medium for cerebral angiography. This paper presents our experience with a new contrast medium, Meglumine Iothalamate 60% (Conray®), in performing carotid, vertebral, and right and left direct non-catheter brachial angiography studies in the past twelve months. Right and left direct brachial angiography is a new method of angiography employed by us. For a complete neurovascular study, one must visualize the extent of the disease process in both carotid and both vertebral arteries in their complete course. More than one vessel is usually involved in atherosclerosis and it is difficult, simply by clinical data, to differentiate obstructive lesions of the carotid vessels from those in the vertebral basilar complex.

Pharmacologic Data

Meglumine Iothalamate 60%† is a sterile, highly water-soluble, aqueous solution of the N-methylglucamine salt of iothalamic acid, a new chemical entity synthesized and developed by Mallinckrodt Chemical Works. Iothalamic acid has a molecular weight of 614 and an iodine content of 62% (Fig. 1). The relative viscosity (in centipoise with H_2O as unity) at 25°C is 6.1, and at 37.5°C it is 4.0. It contains 28.2% W/V iodine content and is a clear, watery solution at room temperature.

FIGURE I

Iothalamic Acid (5-acetamide-2,4,6-triiodo-N-methylisophthalamic acid)

CO_2H ; I ; I ; I ; CH_3-C(=O)-NH ; C(=O)-NH-CH_3

Empirical formula	$C_{11}H_9O_4N_2I_3$
Molecular weight	614
Iodine content	62%

Pharmacological studies carried out by Hazelton Laboratories, Inc., consisting of intracerebral administration of Meglumine Iothalamate 60% and Sodium Diatrizoate 50% in mice showed a lower intracerebral LD_{50} for Meglumine Iothalamate (Table I). A study was also carried out on the blood-brain-barrier in dogs.

TABLE I

INTRACEREBRAL ADMINISTRATION

(See reference 1.)

Mice	Intracerebral LD_{50}	Confidence Limits
Meglumine Iothalamate 60%	200 mg/Kg	153 - 216
(Duplicate studies)	147 mg/Kg	111 - 194
Sodium diatrizoate 50%	62 mg/Kg	43.7 - 88
(Duplicate studies)		
Control	66 mg/Kg	———

This consisted of rapid injection of the common carotid artery in ten seconds with 35 cc. of Meglumine Iothalamate 60% followed by an intra-arterial infusion of trypan blue dye. The animal was then sacrificed by exsanguination and the brain was removed. Comparative

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†Meglumine Iothalamate 60% was supplied by Mallinckrodt Chemical Works, St. Louis, Missouri.

studies with normal saline solution, Diatrizoate Sodium 50%, and Meglumine Iothalamate 60% were carried out. The degree of visible brain staining served as an index of the degree to which the contrast medium had increased the permeability of the blood-brain-barrier. Least brain staining was observing following the intra-arterial injection of Meglumine Iothalamate 60%[1]. In Table II, a comparison study of some common opaques used for cerebral angiography is presented.

TABLE II

COMPARISON OF SOME COMMON OPAQUES

	Relative Viscosity (in cups with H_2O as unity)		Iodine Content	Appearance	LD_{50} Mg/Kg in mice. Manufacturer's figures)
Conray 60%	25°C 37.5°C	6.1 4.0	28% W/V	Clear, watery solution	17,000+ 1,000
Angio-Conray 80%	25°C 37.5°C	14.4 8.4	48% W/V	Clear, watery solution	19,000
Renovist	25°C 37.5°C	9.1 6.12	37.2% W/V	Clear, watery solution	14,500
Renografin 60%	25°C	6.0	29% W/V	Clear, watery solution	———
Hypaque 50%	37.5°C	3.1	30% W/V	Clear, watery solution	———

Clinical Data

Meglumine Iothalamate 60% was used for 350 common carotid arterial studies with a total of 2,132 injections (Table III). The average amount used per injection was 8 cc. and the average total volume per patient was 50 cc. In all cases the examination was carried out under local 1% Xylocaine® anesthesia and premedication of Demerol®, 50 to 100 mg., intramuscularly thirty minutes prior to the procedure.

TABLE III

CEREBRAL ANGIOGRAPHY	INJECTIONS	EXAMINATIONS
Common Carotid Artery	2,132	350
Vertebral Artery (Direct)	8	8
Brachial Artery		
Right Direct Non-Catheter	68	50
Left Direct Non-Catheter	72	55
Total	2,280	463

Each patient was observed for signs of untoward local or systemic reactions of hypersensitivity. The common side effects were felt to be less than usually seen with another common contrast medium used for cerebral angiography and no serious reactions occurred (Table IV). One of the outstanding features noted was less vessel burning and flush. The head rotation seen with some of the common cerebral contrast media was not observed. Very few facial grimacings were observed. Accidental extravasation of Meglumine Iothalamate 60% produced less local reaction and discomfort. When this occurred, hot compresses were applied to the area and relief of pain and swelling occurred in twenty-four hours or less.

TABLE IV

COMPARISON OF SIDE EFFECTS

Side Effect	Meglumine Iothalamate 60%	Sodium Diatrizoate 50%
Dizziness	1%	1.5%
Vessel Burning	12.8%	24.7%
Flush	12%	22%
Nausea	0%	2%
Vomiting	1%	3%
Dyspnea	1%	4%
Pain (site)	20%	28%
Taste	0%	1%
Urticaria	0%	1%
Head Rotation	0%	3%
Palpitation of Heart	0.3%	1%
Extravasation	1%	1.5%
Facial Grimacings	2%	8.8%
Seizure	0.3%	1%
Number of Patients	350	100

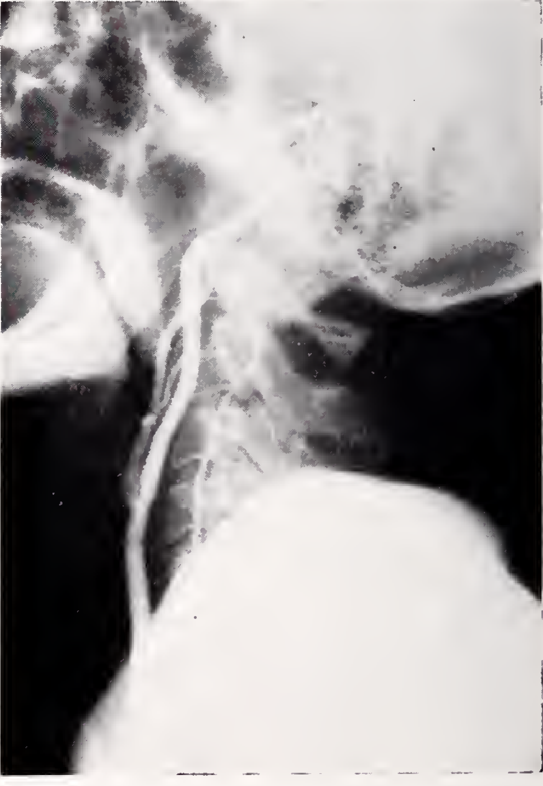

Fig. 2—Lateral view demonstrating a normal right vertebral artery using forty cc. of Conray 60%.

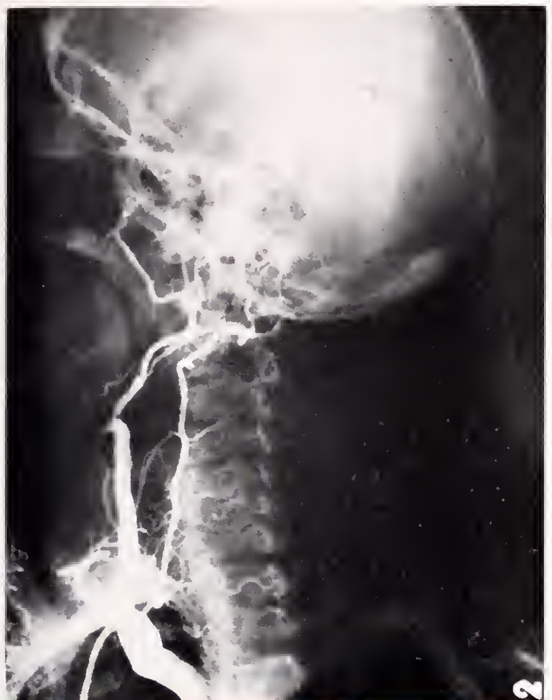

Fig. 3 — Complete arteriosclerotic occlusion of the right internal carotid artery at the point of origin. Normal right vertebral artery.

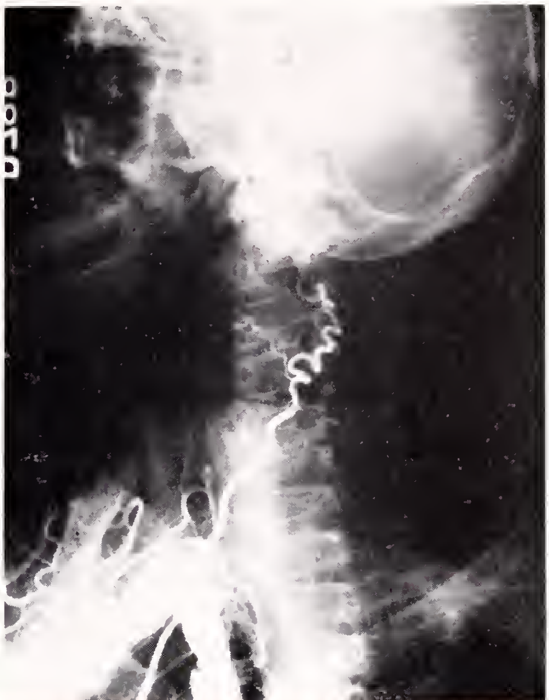

Fig. 4—Complete arteriosclerotic occlusion of the right common carotid artery and 60% narrowing of the innominate artery.

Direct vertebral arteriography was performed on eight patients with no appreciable side effects. In the last few months, right and left direct non-catheter brachial artery injections have been performed instead of direct vertebral puncture for study of the vertebral artery and branches (Fig. 2).

Direct percutaneous non-catheter left and right brachial angiography was performed on 105 patients without any serious side effects[2]. Right brachial artery injection gives excellent visualization of the right vertebral and basilar artery, innominate, right common carotid arteries, and cerebral branches (Fig. 3, 4, 5). Direct percutaneous injection of the left common carotid artery completes the study. Left brachial artery injection (panarteriography) permits visualization of the left vertebral, thoracic and abdominal aorta, renal arteries and femoral arteries by one injection (Fig. 6). 30-35 cc. of 60% Meglumine Iothalamate is used for right brachial cerebral angiography in adults. 60-70 cc. of 60-% Meglumine Iothalamate is used for the left brachial pan-arteriography method. Injection is performed with a Gidlund automatic injector using a pressure range between 7.0 to 8.0 Kg/cm_2 pressure or a special automatic pressure injector designed by one of us. (TRM). This injector is lightweight, portable, and assures a more constant back-up pressure. In patients with marked hypertension a higher pressure is required. A special thin wall needle with a blunt end and fine pointed obturator and a special base plate is employed for arterial puncture. (B.-D. Co-Marshall X-15162) A pressure above the systolic blood pressure in the brachial artery should be applied below the needle during the injection. In our experience, this method gives excellent results and very few side effects have been observed. This method enables one to visualize the blood supply to the brain without undue risk to the patient. Fewer side effects have been noted from this method than from direct puncture of the common carotid artery.

For direct non-catheter right brachial artery injection, a modified Towne projection and a lateral projection are used. In the modified Towne view the central ray is directed at a 25 to 30 degree angle caudad, with the head in slight flexion. A Sanchez-Perez rapid cassette changer is used and films are exposed at 0.5 second intervals for 4 seconds. On the lateral projection, the bifurcation of the common carotid artery in the neck and the entire skull are included. Compression of the left

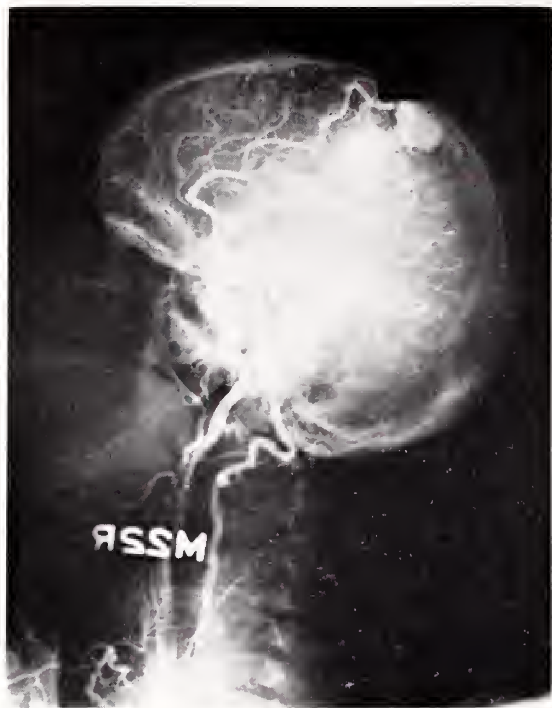

Fig. 5—Direct non-catheter right brachial angiogram in the lateral position showing a large arteriovenous fistula. Note the excellent filling of the cerebral circulation.

common carotid artery during right brachial artery injection gives filling (through the anterior communicating artery) of the left anterior and middle cerebral arteries.

Out of this series of 105 patients, we failed to enter the artery 4 times. No deaths occurred. One patient had a left-sided seizure that lasted for 30 seconds, followed by a left hemiparesis that cleared in one week.

A 14 x 17-inch AP film of the abdomen is obtained routinely ten minutes after the last injection for visualization of the renal collecting system and bladder. This will frequently demonstrate unsuspected renal pathology.

Discussion

Smolik and Nash[3] reported in their experience with 110 cerebral angiograms that Meglumine Iothalamate 60% gave excellent contrast and radiographic quality without untoward local or systemic reaction.

The low viscosity of Meglumine Iothalamate 60% increases the speed and ease of injection. It does not cause any sticking of the barrel of the syringe as experienced with some contrast media. Meglumine Iothalamate 60% produces excellent demonstration of the right vertebral, carotid and cerebral vessels via the right brachial method.

Complete visualization of the cerebral circulation and the entire length of the vessels from the aortic arch is necessary for a complete and accurate diagnosis of cerebrovascular disease. Combined right brachial artery study and direct injection of the left common carotid artery gives this result and the complete examination can be performed in 30 to 45 minutes.

Direct non-catheter brachial angiography is relatively painless and produces no severe spasm of the brachial artery as is sometimes seen when a catheter has been inserted. Patients complain less from brachial artery puncture and the usual side effects of contrast media injection than when direct injection of the common carotid is performed. A smaller puncture hole in the brachial artery is needed since no catheter has to be inserted.

Our experience with brachial angiography has demonstrated that the circle of Willis functions in a variable pattern.

In order to prescribe a suitable treatment, endarterectomy or anticoagulant, for acute or chronic cerebral vascular insufficiency, a complete topographic survey of the entire arterial supply to the brain is mandatory.

It is hoped that a better understanding of the cerebral circulation and hemodynamics will be obtained with this new method. A stenosis of

Fig. 6—Normal brachial renal arteriogram 60 cc. of Meglumine Iothalamate 60%.

the left subclavian artery proximal to the origin of the vertebral artery can produce a reversal of the blood flow (subclavian steal) in the left vertebral artery.

Summary and Conclusion

A new method of performing cerebral angiography by direct non-catheter right and left brachial artery injection is discussed, in combination with direct injection of the left common carotid artery. Visualization of the entire cerebral circulation is obtained. Brachial artery injection does not subject diseased vessels to direct puncture and is a simple and safe procedure.

Meglumine Iothalamate 60% is an excellent contrast medium for cerebral angiography. It produces good radiographic contrast and very few unpleasant side effects. In our experience, it has been noted to be superior to the common contrast media employed for cerebral angiography. Four hundred and sixty-three cerebral angiograms of all types have been performed with this new contrast medium. Intracerebral studies in mice showed a lower LD_{50} than Sodium Diatrizoate 50%.

Direct Non-Catheter Brachial Angiography is relatively painless and produces fewer and decreased side effects than direct injection of the Common Carotid artery in the neck. Injection of the contrast medium produces less pain and vascular burning.

Addendum:

We have now performed a total of 350 non-catheter left and right brachial arteriograms without a fatality or major complication. In 25 patients non-catheter axillary artery injection has been performed satisfactorily. However, this method is not as safe as brachial artery injection, because if extravasation should occur, damage to the infroclaviclar portion of the brachial plexus may result.

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Renal Hypertension†

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Improved Diagnostic procedures have made possible detection of renal vascular lesions, producing hypertension. Proper application of these refined techniques is necessary for accurate diagnosis and for proper selection of surgical candidates.

THE pressor effects of extracts of renal tissue were demonstrated in 1898. Richard Bright associated hypertension with glomerulonephritis but it remained for Goldblatt[1], in his classic study, to produce sustained hypertension experimentally by constricting a main renal vessel with resultant renal ischemia. Intensive investigation of the efect of renal ischemia has followed with considerable elucidation of the biochemical process involved. It has been determined that renin[2], an enzymatic protein is elaborated by the kidney and acts upon a substrate produced by the liver to form angiotensin I. This decapeptide is converted by an enzyme found in plasma to angiotensin II, an octapeptide, the most potent vasopressor known.

Intensive investigation has failed to produce a specific antihypertensive factor which would interrupt the production of angiotensin in the presence of renal ischemia. The surgical approach to renal hypertension fell into disrepute when Homer Smith, in 1948, found that only 20% of hypertensive patients responded to Nephrectomy. Improved diagnostic techniques and careful selection of patients has redefined this group of patients with surgically remediable hypertension and it has proven far larger than was previously believed.

†*Presented at the Kenlake Seminar, Kentucky Academy of General Practice, held at Gilbertsville, Ky., on July 19, 1962.*

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Selection Of Patients

Hypertension is a clinical sign evident in nearly 10% of adult Americans[4]. In only 5-10% of this group is the etiology of the hypertension determined. Coarctation of the aorta, adrenal cortical and medullary diseases, and thyrotoxicosis account for a small percentage of this group. Bilateral parenchymal renal disease, especially glomerulonephritis, constitutes the bulk of the remaining patients with specific etiological diagnosis. It is in those without specific diagnosis that renovascular hypertension susceptible to surgical remedy will be found.

Ideally, all hypertensives should have a complete renovascular evaluation. The discomfort, inconvenience and hazard involved make this impractical and makes necessary the careful selection of patients. Those with hypertension which can otherwise be accounted for are not studied. Investigation of patients with a familial type essential hypertension is rarely rewarding. Aggressive investigation is pursued primarily in hypertensive patients less than 35 years of age, those with disparity in size or function of the kidney, sudden onset or progression of hypertension and in elderly patients with malignant hypertension. Careful selection has been rewarded by finding many potentially curable patients who, otherwise, would have received ineffective medical therapy. Using these criteria to select patients, Poutasse[5] found that 30% of them had primary vascular lesions of the main renal vessels and 12% had significant pyelonephritis.

Finally, a renovascular evaluation should be done only if the health of the person being evaluated is such that reconstructive surgery, if it should be necessary, if feasible.

Renal Diagnostic Techniques

Diagnostic procedures for detecting potentially remediable hypertension of renal origin

include primarily excretory urography, differential renal function tests, the radioactive renogram, and renal angiography. An attempt should be made to select carefully the most appropriate studies for the particular patient but it is often desirable and even necessary to employ a combination of these for adequate evaluation.

Excretory Urography

Excretory urography is the most widely utilized renal diagnostic study. It provides a comparative examination of renal structure and function which is essential. Tumors, hydronephrosis, pyelonephritis and other primary renal pathology capable of producing hypertension are thus demonstrated. Primary renovascular lesions will produce disparity in size or function of the involved kidney in nearly 50% of patients with renovascular disease[6]. The efficacy of this examination is enhanced if the technique is altered for study of hypertensive patients. Exposures taken at one minute intervals for the first five minutes after injection will very frequently reveal altered function not apparent on a five minute film. In the search for unilateral renal dysfunction the multiple early exposures make the IVP far more useful. This is at best a screening procedure, with inherent deficiencies. Early unilateral renal artery lesions and most bilateral renal artery involvement will not be detected without other diagnostic determinations.

Differential Renal Function Tests

Differential renal function tests have developed as an understanding of the physiological changes which result from vascular lesions has accrued. Howard[7] noted that renal artery constriction produced increased tubular reabsorption of water and sodium. Other elements in the glomerular filtrate were therefore in relatively greater concentration. Using this information, Howard noted that those hypertensive patients who had a decrease in urine volume of 50% or more and in sodium concentration of 20% or more had unilateral renal disease producing hypertension which could be surgically corrected. This test must be performed very carefully if results are to be reliable. Leakage about ureteral catheters can invalidate volume determinations and trauma from ureteral catheterization can result in bleeding which may alter the sodium concentration. Therefore, careful placement of the ureteral catheters and repeated studies are often necessary to assess properly separate renal function. Rapaport[8] has compensated for inaccuracies in volume determinations by quantitatively comparing urine sodium and creatinine concentration from each kidney and has evolved a formula, the tubular rejection fraction ratio, which will detect unilateral renal vascular disease.

While differential renal function studies have proven very valuable in the diagnosis of unilateral renal disease, they have certain basic defects. First, bilateral renal artery involvement, seen frequently in arteriosclerotic disease, will not be detected. Second, lesions of segmental branches of the renal artery may induce hypertension without altering, significantly, urine sodium or water excretion. Third, parenchymal disease may alter the response of the kidney. Pyelonephritis, in particular, will cause increased sodium concentration and a false negative result. Finally, while this test indicates the side of involvement, the exact nature of the offending lesion must be determined by urography and/or renal angiography before a surgical approach is planned.

Renal Angiography

Specific diagnosis of renal vascular lesions depends upon radiographic demonstration of the renal vasculature. Technical advances have eliminated many of the inadequacies and hazards inherent in translumbar aortography. The Seldinger technique of transfemoral aortography permits proper positioning of the catheter in the aorta without danger to mesenteric, spinal or renal vessels. When used with multiple film exposures this technique permits visualization of the main renal vessels, the segmental vascular pattern and the initial nephrogram. Not only the primary vascular lesions are evident but also segmental vascular deficiency, unapparent by other diagnostic techniques, may be determined.

Angiography is essential in planning renovascular surgery. Localization of the lesion will determine whether endarterectomy, resection of a stenotic artery, a splenorenal shunt, a bypass graft, a partial nephrectomy or a total nephrectomy is the treatment of choice. Preservation of renal tissue is essential in hypertensive patients and it should be noted that the kidney

with the vascular lesion is protected from the ravages of hypertension by this obstruction. Very often this affected kidney will have a better chance for restoration of normal function than the opposite kidney which will show hypertensive degenerative changes.

Careful interpretation of renal angiograms is necessary if a surgical misadventure is to be avoided. Many apparent obstructive lesions of renal arteries have been noted in patients without hypertension. This has been particularly true in older people with generalized arteriosclerotic disease. Arteriosclerotic plaques are frequently seen in renal vessels at autopsy when no hypertension had been present antemortum. Careful interpretation of arterial lesions seen in patients with generalized arteriosclerosis is necessary and full consideration must be given to other facets of the renal evaluation.

Despite its deficiencies, renal angiography is the most valuable single diagnostic tool now available.

Radioisotope Studies

The use of radioisotopes that are excreted by the kidney has provided a new and promising avenue for investigation of differential renal function. In 1956, Winter[9] reported the use of radioactive Diodrast® in the study of renal function. He demonstrated a standard radioactive pattern over each renal mass as the material perfused the kidney. It is possible to determine whether there is impaired renal vascularity, function or drainage by the patterns produced. As a screening test in the search for renal hypertension it is significant only when it is positive. There must be a 20% decrease in renal perfusion for positive detection by the radioactive renogram. It will have some false negative results but has been reported accurate in 80% of one series[6] of patients with proven renal hypertension. This procedure is safe, relatively painless, and simple to perform. With further refinement this may prove to be the best screening test available in the evaluation of hypertensives.

Summary

Hypertension due to vascular lesions of the renal arteries is far more common than has generally been realized. While it comprises a small segment of the total hypertensive population, it is by far the largest group that can be corrected surgically. Improved diagnostic techniques have delineated a rather large group of hypertensive patients who have specific etiological lesions and for whom definitive therapy is available.

There is as yet no simple screening test that is completely reliable. Of the newer procedures, the radioactive renogram seems to offer the best hope for a simple, safe and effective method for screening these patients. It has not, as yet, proven sufficiently reliable to be depended upon when used alone.

Excretory urography offers a simultaneous study of renal structure and function. The effectiveness of this exam is increased by making multiple exposures shortly after injection of the contrast material. Aortography is necessary to delineate the site of the arterial obstruction and is the only technique which will disclose bilateral renal artery stenosis. An anatomical study alone does not relate structural defects to the disturbed physiology. Thus far, the study of urine obtained simultaneously from both kidneys has been most informative in the search for renal hypertension amenable to surgical treatment. Only bilateral renal artery stenosis, pyelonephritis, and some segmental arterial lesions have eluded proper use of this diagnostic probe.

Despite certain deficits in our knowledge of renal hypertensive disorders, better understanding has allowed us to distinguish this group. If the diagnostic tools mentioned above are properly utilized, it is now possible to define many cases of renal hypertension which formerly defied diagnosis, and, what is equally important, accurately predict which lesions can be corrected by surgical treatment.

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Current Concepts in the Surgical Management of Pulmonary Tuberculosis†

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Early adequate therapy may inactivate Pulmonary Tuberculosis without surgery. Resection of destroyed lung tissue is the procedure of choice. Paulino thoracoplasty may be used in poor risk cases.

Tremendous advancements have been made in the past fifteen years in the treatment of pulmonary tuberculosis. This has occurred in both the medical and surgical fields. During this period of advancement, many concepts have been proven, others tried and rejected and still others remain to be tried. A brief review of some of these concepts from the surgical aspect will be given.

At the onset the tubercle bacillus produces a pneumonic lesion. If the resistance of the host is great enough the lesion may clear without therapy. The cases we see are the ones that fail to clear. The value of early therapy is well known. We wish to emphasize adequate as well as early. Cohen has recently reported on the difficulties encountered in drug resistant tuberculosis.[1] Tarshis suggests the problematic atypical mycobacterium may be mutations produced by drug therapy.[2] With early adequate therapy, very few patients will need surgical therapy. The fact that a patient is getting drugs does not mean adequate treatment. Without adequate supervision lesions may fail to clear or fibrose, thus increasing the number of cases requiring surgery. In addition, the number of drug resistant cases may increase.

An Illustrative Case

Case No. 1 is that of a 19-year-old white female whose treatment began in February 1961. (Fig. 1) The onset of her symptoms was two months prior to admission. There was very adequate response to INH, 600 mg. and PAS, 10 gm. daily with Streptomycin, 1 gm. three times per week. Resolution of the pneumonic element was marked. A cavity in the right upper lobe cleared without residue but cavitation on the left persisted. Surgery was offered the patient but she refused. She was permitted to leave the sanatorium on Nov. 9, 1961, with a supply of free drugs. She was re-admitted to

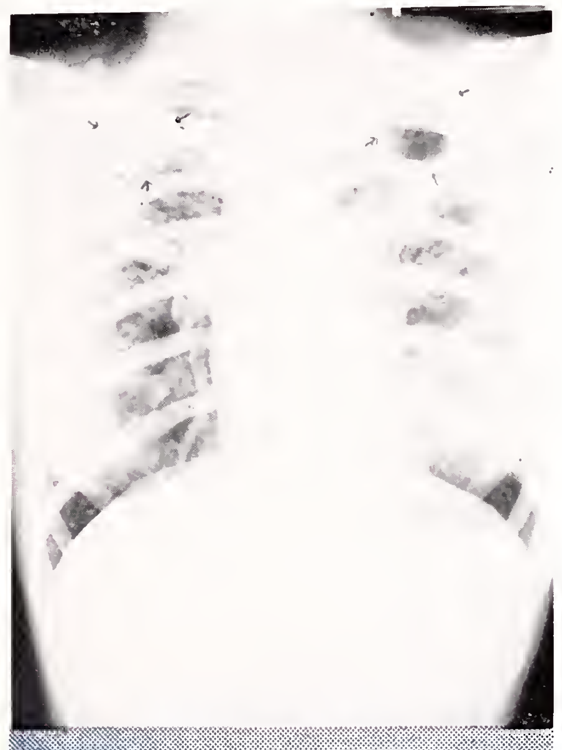

Fig. 1 (A). X-ray of chest before chemotherapy—bilateral cavitation.

the sanatorium Feb. 5, 1962, after a bout of hemoptysis three weeks earlier. Her sputum on the first admission had revealed organisms resistant to INH and PAS. In spite of this, her sputum became negative in July 1961. The admission x-ray on Feb. 5, 1962 revealed a spread of her disease into the left lower lobe with an increase in the size of the cavity in the left upper, and her sputum was again positive.

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†*Presented at the Spring Meeting of the Kentucky Trudeau Association, held April 26, 1962.*

**Kentucky State Tuberculosis Hospital, District Two, Louisville, Ky.*

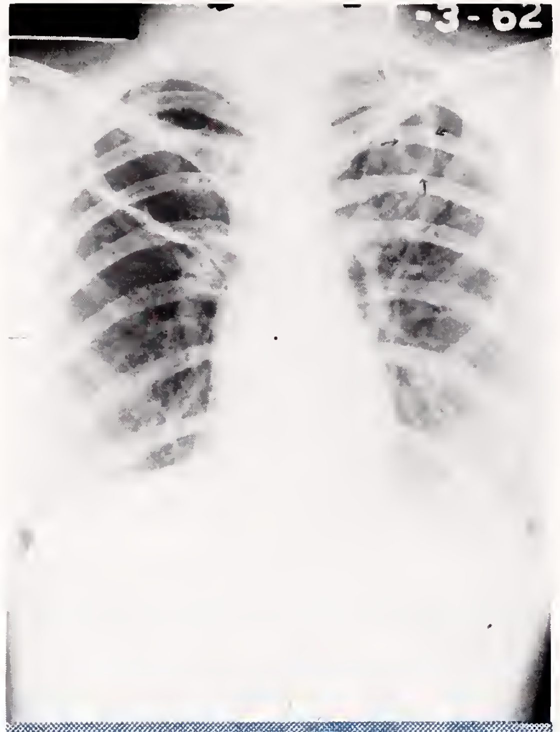

Fig. 1 (B). Cavity in left upper lobe. Cavity on the right closed. Surgery refused by patient.

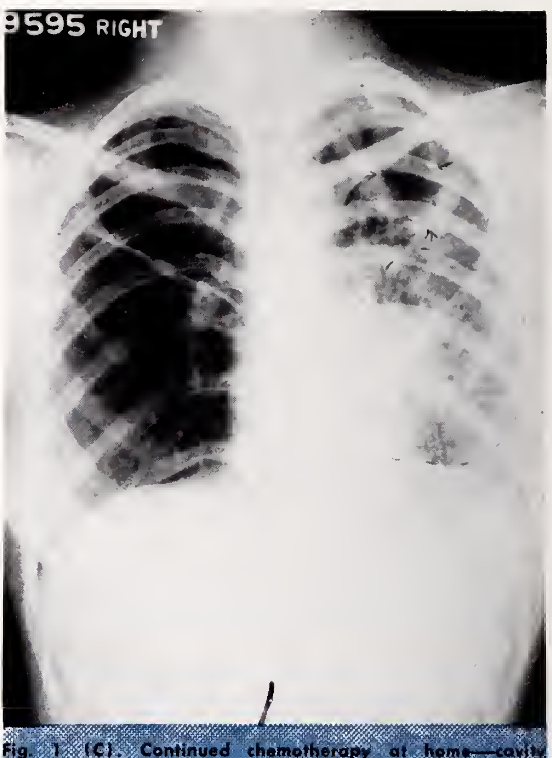

Fig. 1 (C). Continued chemotherapy at home—cavity larger with spread in left base.

Cycloserine, 250 mg. b.i.d. and Pyrazinamide, 500 mg. t.i.d. were added to the previous regimen. After two months there was marked improvement in her x-ray and her sputum became negative on smears, with cultures pending.

This case illustrates that there is more to the treatment of pulmonary tuberculosis than the dispensing of drugs. This is especially true in the cases with resistant organisms. Numerous articles are now appearing in the press suggesting that the mere taking of drugs at home is all that is needed. This case is only one of numerous instances encountered in our sanatorium program where progression has occurred even though patients continue medication after leaving AMA. We cannot help but wonder if it does not help the physician more than the patient when medication is prescribed in this manner.

Delay in treatment may lead to destruction of the involved lung. This may be cavitary, fibrosis with bronchiectasis, bronchial stenosis, and empyema. If the area of involvement is great enough, emphysema of the uninvolved lung may occur. In some instances the disease is superimposed on a lung with advanced emphysema. The latter markedly increases the problems of the medical and surgical therapist.

The duration of medical therapy before considering surgery is a variable. In the case of coin lesions or tuberculomas, surgery is frequently done without a course of preoperative chemotherapy. In the case of active lesions with positive sputum we like the patients to get a minimum of three to four months therapy. On the whole, most patients in our program receive medical therapy six months to one year. We feel that medical therapy should be continued as long as the patient is improving.

Occasionally an early case with a small cavity will be seen. In such a case a short course of drugs (three to four weeks) can be given and the patient then operated on. We cannot accept the concept that surgery is needed whenever a patient has a cavity. Every week in our x-ray conferences we see cases in which cavities have closed and stratigrams fail to reveal any residua or at the most, a thickened fibrous strand. A lesion that responds in this manner is just as inactive as if it were removed. This was well illustrated in Case No. 1 in the right lung. On the other hand, a cavity may become inspissated with tuberculous caseous material. If these foci are large, surgery may be indicated, but again these cases must be individualized. A teenager with large foci limited to one segment or lobe might be a candidate for excision but a dyspneic 70-year-old patient would not.

Excisional surgery is now safe enough that surgery is indicated when the patient's physical status will permit. The role sputum plays is quite different than it was many years ago. At one time it was rare to operate on a patient with negative sputum. Today we prefer to operate on patients with negative sputa, for the incidence of postoperative complications is higher in patients with positive sputa.

Surgical Intervention

With certain types of cases the indications are quite clear-cut, such as, the cavity that fails to heal after several months of adequate medical therapy, the destroyed lung or lobe with extensive bronchiectasis and cavitation, and repeated bouts of hemoptysis secondary to bronchiectatic disease. Chronic tuberuclous empyema, much less common than in previous years, is still an indication for surgical intervention if it fails to respond to medical measures.

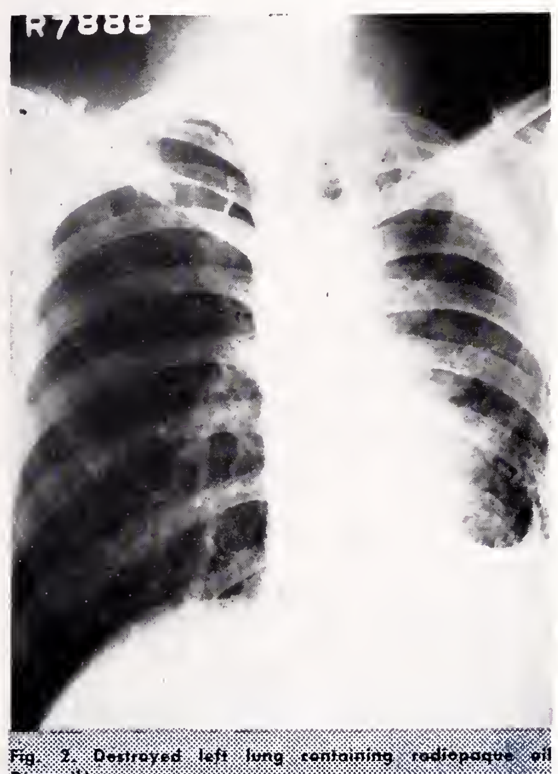

Fig. 2. Destroyed left lung containing radiopaque oil Dionosil).

At the present time, our routine operative procedure is pulmonary resection. This procedure has certainly withstood the test of time. Since August of 1949 we have done 1,665 resections. Numerous statistical reports have appeared in the literature; therefore, we are not giving such a report at this time. Much emphasis must be given to the well known fact that all lesions cannot be resected. In this light, adequate postoperative medical care is essential. This should not only include medication but adequate food, shelter, and relative freedom from emotional problems. Excessive activity should also be avoided. It should be emphasized that resections in tuberculosis are still accompanied by complications such as postoperative hemorrhage, residual spaces with or without empyema, wound breakdown, pulmonary insufficiency and persistently positive sputum. As our experience has increased, the number of complications had diminished. One of the chief reasons for this is better case selection.

Two types of cases give us the most concern. One is the case with thin-walled cystic areas or blebs in the apices. Are these tuberculous cavities? We have removed some of them but I am not sure it was necessary. We have not fully accepted the concept of open healed cavities. Sputum studies cannot be relied upon. Doctor Beatty and his associates have been doing cavitary studies on these patients.[3] A needle is inserted through the chest wall under local anesthesia and pressure readings are taken. A small amount of Dionosil is instilled into the cavity and x-rays are made. This procedure outlines the cavities well but has failed to give us a definite answer. In a few cases we have followed this with direct visualization of the lining of the cavity, which we call cavernoscopy. Using pneumonolysis equipment, a trocar and cannula are inserted into large cavities. Thru the cannulas we are able to insert for-oblique and right angle telescopes. Granular as well as epithelialized areas can be seen. Dionosil, which is white, can be seen on epithelialized as well as granular surfaces. The bronchial communications can also be seen. In our small series of seven cases complications have been limited to subcutaneous emphysema. We plan on continuing this study and perhaps some day this might give us the answer. In properly selected cases it is a safe procedure.

Case Histories

Case No. 2 Patient is a 27-year-old male with disease of eight years duration. (Fig. 2) Positive sputum was obtained intermittently for seven years. Eight months prior to admission his sputum was negative on smear and culture. At cavernoscopy the upper portion of the cavity

Fig. 3 (A). Preoperative stratigram showing bilateral cavitation.

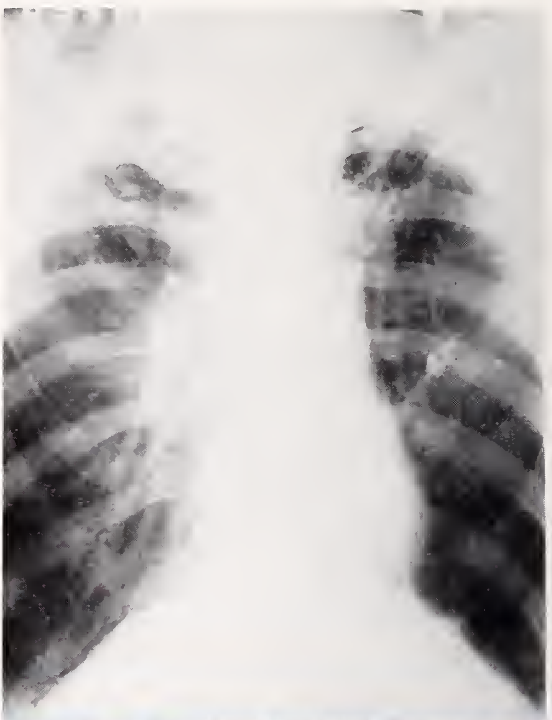
Fig. 3 (B). X-ray appearance after bilateral Paulino thoracoplasty. Note large blebs on left.

was smooth and glistening. In the dependent portion of the cavity trabeculation was noted covered over with patches of Dionosil. There were also some reddish, granular areas not covered over by the oil. The pathologist reported lung cyst with superimposed chronic inflammation, but no typical tuberculous lesions. In this case surgery was indicated because of a destroyed lung, but from a tuberculosis standpoint was it necessary in order to maintain a negative sputum status?

The second type of case we frequently encounter is the patient with marked emphysema. The indications for surgery are present but will the patient tolerate it? The emphysematous process at times is unilateral, being secondary to extensive destruction of the upper half of the lung. Resectional surgery may lead to a pneumonectomy. The latter not only means loss of functioning lung but also subjects the patient to the possibility of bronchopleural fistula and empyema.

In recent years we have managed such cases with a Paulino thoracoplasty. This procedure was introduced in the United States by DeCamp in 1953.[4] The disease process must be confined to the area above the level of the hilum. A short segment of ribs two, three, and four are removed. An extrapleural operation is then done down to the level of the hilum on the mediastinal surface. It can go below the level of the superior segment posteriorly and laterally. A series of three to five purse string sutures of No. 2 silk is used to constrict freed-up lung. We have done twenty-four cases and are quite pleased with the result. To date we have had two empyemas and have failed to control the disease in two cases. Two patients have died—one from postoperative embolism and the other a late cardiac death. This procedure is not intended to replace resection. It can be used in certain cases that will not tolerate resection. The diminution in pulmonary function is far less than one would get with a conventional thoracoplasty or resection.

Case No. 3 This patient was a 41-year-old white male with a history of pulmonary tuberculosis of one year's duration. (Fig. 3) Bilateral cavitation was seen on stratigrams. Pulmonary function study preoperatively revealed vital capacity, 60% of normal; timed vital capacity, 42% in one second, 66% in three seconds, and maximum breathing capacity, 50% of normal. A bilateral Paulino procedure was done. The patient's sputum has remained negative. He is still dyspneic but able to take care of himself at home.

The only thoracoplasties we are now doing

done a thoracoplasty is performed in our younger patients, at times simultaneously. With partial excision of the lung, thoracoplasty may be indicated if the remaining lung fails to obliterate the space. In recent years we have been pleased with our results with thoracoplasty on reactivations with apical disease. Our feeling here is that if the thoracoplasty fails we can always do additional excision. In this way we feel we have avoided doing many pneumonectomies.

For chronic tuberculous empyema, decortication is the procedure of choice. In our acute cases we do not believe in early tube drainage if it can be avoided. We have had satisfactory results with repeated chest aspirations, even in our postoperative cases. When aspiration fails, then tube drainage must be resorted to. If wound breakdown occurs with bronchopleural fistula, we resort to Schede thoracoplasty. We feel that extensive surgery in the face of acute infection gives very bad results. We prefer to give our patients supportive therapy with diet, blood, serum albumin, and appropriate antibiotics. After the development of tissue resistance to the infection, we then proceed with a Schede thoracoplasty. We feel that some of the acute postoperative empyema cases that we lost several years ago could have been saved had we not been in such a hurry to do collapse procedures on them.

Rehabilitation

Following surgery, rehabilitation must not be forgotten. Doctors are so busy getting patients well that we sometimes fail to consider the patient's future. A patient is not necessarily totally disabled following lung surgery. Some of our surgical patients have been advised by doctors never to work again. If they are incapacitated we would agree, but all cases must be individually evaluated. In this day and time, with Social Security and other types of welfare payments available, patients often encourage us to say they are disabled. If a patient is not disabled, he will soon become permanently so if not adequately evaluated. It is important that these patients should be encouraged to lead normal lives. In the case of young housewives, pregnancy is even encouraged. At this time we have had only one patient reactivate postpartum. During periods of stress, we do encourage family doctors to give these patients two to three months of drug therapy.

Summary

In recent years, numerous antituberculous chemotherapeutic drugs have been developed and the surgeon has become more proficient in his ability to excise diseased lung. The best prophylaxis of surgery is not only early treatment but adequate as well. Pulmonary resection is our most common operative procedure. Diagnostic studies currently in use to determine if a cavity is healed are described. The use of cavernoscopy to inspect the inner surface of cavities is described. In selected cases with poor pulmonary function suture constriction of the lung (Paulino thoracoplasty) has given encouraging results. Indications for post-excisional thoracoplasty are given. The role of the physician in rehabilitation of the post-surgical patient is stressed.

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EDITORIALS

Back To The Bluegrass

THIS year we go to Lexington. Last September the Fayette County delegates were so insistent and logical in their propaganda that the House voted to accept their invitation—thus breaking a twelve year series of annual conventions in Louisville.

Lexington has much to offer as a convention attraction. It is the home of Transylvania—of Henry Clay and of Daniel Drake. It was a famous Medical Center when Louisville was but a whistle stop and a loading platform for the then flourishing Ohio River traffic. With the new Albert B. Chandler Medical Center of the University of Kentucky the city has recaptured its place in the Medical Sun. One must see the new school and hospital with its fine auditorium and library, its modern appointments, its Dean and his excellent faculty to appreciate, in some measure, what it is adding to Kentucky.

The medical profession in Lexington is unique. There are more physicians per square inch—and a greater proportion are American Board qualified—then in any city of comparable size in the world. In fact we outsiders wonder how they all survive. They just seem to want to live in Lexington and there they settle down and stay—and we haven't heard of one of them starving yet. In fact they seem to live exceedingly well.

They are a cordial, friendly, hospitable lot, and make magnificent hosts on such occasions as that planned for September. They practice good medicine. Their Blue Cross-Blue Shield hospital experience regarding hospitalization per 100,000 annually, length of stay, usage of ancillary services—has consistently been better than for any other city in the state. We get a high ratio of contributions to this Journal from Lexington physicians—from the school faculty and outside. Maybe this all has some significance; it would seem to suggest that the better trained physician will practice better medicine and contribute more effectively to medical progress.

But Mr. Joe Sanford behested me to advertize the quality of the meeting—not necessarily to praise Lexington and its profession. He wanted me to tell about the fifteen leaders in their respective specialties from as many medical centers, who will enhance the excellence of our program; of the four hours of improved color television originating in the new U. of K. Hospital and sponsored by our long time friends, Smith Kline & French; of the scientific exhibits; of the class reunions; and of the testimonial dinner honoring Dr. Kinsman, recent Dean of U. of L. School of Medicine. These and a lot of other things, including exceptional entertainment opportunities for the ladies and golf for the golfers, he urged me to detail.

Our peak attendance of physicians was 1957, when 1,094 registered. There were 1,021 in 1960 and 1,014 in 1962. The housing facilities in Lexington are ample and even luxurious if desired. It will be a good year to break all attendance records—let's do.

Oh, yes—Faithful Old Joe had one more word of advice. These are rather hard times for the Journal. Brother Kefauver has scared away a lot of our advertizers—at least for the present they have went! But our technical exhibitors have stayed with us. They provide much of the money necessary to make our meetings a success and to allow us to invite so many outstanding speakers for our program. These Gentlemen are our friends and supporters. They provide the necessary drugs, and publications and gadgets for our daily work; they bring us new and sometimes revolutionary concepts. We can very profitably divide our time with them.

Visit the exhibits!

Sam A. Overstreet, M.D.

The Kentucky Society For The Prevention of Blindness

THE Kentucky Society for the Prevention of Blindness, a division of the National Society for the Prevention of Blindness, was organized in its present form about two years ago. Previous Sections or Committees of the National Society had existed at various times since the first attempt at such an organization was made in the second decade of this century by Miss Linda Neville of Lexington. Accomplishments of these early attempts were meager and sporadic and interrupted by long periods of inactivity.

However, the present Kentucky Society has made an enviable record in its short life. Under the leadership of President Peyton Hoge, an interested and dedicated Board of Directors assisted by a professional advisory committee of ophthalmologists has established policies and guided activities in keeping with those of the National Society. The Executive Director, Mrs. Ethel Read, has carried out the policies and plans of the Board of Directors in a most capable and efficient manner, making contacts by which prevention of blindness services and activities may be expanded throughout all of Kentucky.

The oldest activity, begun several years before the present Kentucky Society was organized, is the testing of vision of pre-school age children. This program was established by Dr. Charles T. Moran and representatives of the National Office. Dr. Moran trained members of Delta Gamma Sorority to do the actual testing which is carried out in various nursery schools. The program has attracted national attention and has served as the model for similar programs in other cities throughout the United States. Plans are now underway for this kind of testing to be initiated in Shelbyville and Lexington.

The largest project, and one of the most important, was the glaucoma screening program carried out at the State Fair in 1962. Initiated by the Kentucky Society, it was co-sponsored by the United States Public Health Service, the Kentucky State Health Commission and Public Health Nurses, the Eye Section of the Kentucky State Medical Association, and the Department of Ophthalmology of the U of L School of Medicine. Four thousand, four hundred and forty people were screened (tonometric determination of intra-ocular pressure done by ophthalmologiists). Three hundred and thirty-eight suspects were found and referred to their own ophthalmologists or to one selected by their family physician. Careful follow-up, including some personal visits by Public Health nurses, disclosed that 62 cases of previously unknown glaucoma were discovered.

There will be a similar glaucoma screening program at the State Fair in September 1963. It is estimated that least 8,000 persons will avail themselves of this opportunity.

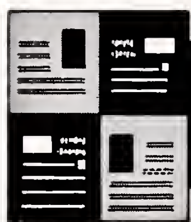
As a direct result of the State Fair screening, five other similar programs have been conducted at Murray, Paducah, Graves County and Marshall County, where 3,327 people were screened and 171 suspects referred.

Another important phase of the work of the Society is encouraging the use of protective glasses or goggles in industry. Membership awards in the "Wise Owl Club" of the National Society were given to 35 people whose eyes escaped injury while at work because they were wearing protective devices.

Finally, many conferences were held, lectures given and moving picture films projected where education in methods of prevention of blindness might be offered.

The aims and the work of the Kentucky Society are altogether worthwhile. Its budget comes entirely from voluntary contributions and deserves the moral and financial support of all the citizens of our commonwealth.

C. Dwight Townes, M.D.



SPECIAL ARTICLES

Murder by Design

Three Ways to Stop It*

HORACE E. CAMPBELL, M.D.
Denver, Colo.

WE ARE TO discuss the traffic accident, a daily item in every newspaper. We live in the midst of it; most of us have had at least one. Many of us fail to grasp its real significance. It is a phenomenon, one of the most important in human history. Let us attempt to place it in realistic perspective.

The Readers' Digest for September 1956 pointed out that from 1775 to 1955, the dead in all this nation's wars numbered 1,130,393. In the period from 1900 through 1955, our traffic dead numbered 1,149,414, or at that time, almost 20,000 more than all the dead in all our wars. The Digest went on to say that in 1955 alone more persons were injured on U. S. highways than were wounded on all the battlefields of the nation's history.

The American forces suffered 142,091 casualties in the three-year Korean war, with 33,629 dead. A large proportion of these were not due to enemy action, but were transportation accidents. The three-year deaths were less than any one year on the highways at home, and the three-year injuries were less than a tenth of any one year's traffic injuries at home.

The world picture is just as disturbing. According to figures supplied by 47 member states of the World Health Organization, 102,532 people (78 per cent of them males) were killed in road accidents in 1957.[8]

Is there a solution to this colossal problem?

Yes, I think there is, but first, we must analyze the single, individual traffic death or injury.

Here, we run into a tangled web of a thousand possible causes of the traffic accident. Hundreds of experts are tangled in this web, getting nowhere, and are not likely ever to get anywhere but deeper.

But what is the cause of the death or the injury itself?

One of the earlier efforts to solve this problem was the study by Mr. Hugh DeHaven published in 1942 of nine cases of falls from high buildings with survival.[3] His conclusion was that:

"The human body can tolerate and expend a force of two hundred times the force of gravity for brief intervals during which the force acts in transverse relation to the long axis of the body.

"It is reasonable to assume that structural provisions to reduce impact and distribute pressures can enhance survival and modify injury within wide limits in aircraft and automobile accidents."

Note that this was published in 1942. The design and construction of automobiles in 1963 would give very little evidence that this study was ever made or these conclusions reached.

Some of you may remember from high school days the formula for the velocity of falling bodies (bodies falling in a vacuum, of course).

$$\text{Velocity} = \sqrt{2\,(\text{gravity acceleration})\ \text{x}\ (\text{distance in ft.})}$$

A practical derivation from this formula is the following:

$$G = \frac{(\text{mph})^2}{30\ \text{x stopping distance in feet}}$$

When a car occupant crashes into the structures in front of him, his stopping distance can be estimated generously as about two inches. At the eminently legal speed of 30 mph, the formula yields the following answer:

$$G = \frac{30\ \text{x}\ 30}{30\ \text{x}\ 1/6} = 180$$

This force is well under the figure of 200 G postulated by Mr. De Haven, but the joker is that the force is concentrated on the head, face and chest, and also is imposed by hard, irregular, unyielding surfaces and structures. A wooden roof, a collapsible metal ventilator box, or a well-spaded garden plot would be a godsend to the motorist in this situation. Consider his plight at 60 mph.

$$G = \frac{60\ \text{x}\ 60}{30\ \text{x}\ 1/6} = 720$$

Many thousand such cases have been recorded in the newspapers.

The occupant of the motorcar, having acquired kinetic energy from the sun's rays of a million years ago, finds himself unable to lose this energy in a slow and controlled fashion, but must suddenly divest himself of it in an explosive manner. The explosion kills him.

**Presented before the meeting of the Jefferson County Medical Society on May 20, 1963.*

Speaking in epidemiological terms, William Haddon, Jr., M.D., has pointed out that man is the host; the agent is kinetic energy; and the automobile is the vector, as, in certain circumstances, is man himself.

The answer, of course, is that the automobile is well designed for unimpeded forward motion, is developing more efficient brakes as a corollary to its increasing speed and power, but is in a most rudimentary stage of development as far as sudden deceleration is concerned. It has taken us ten years to get two seat belts in our cars, and this is but the tiniest beginning. The automobile can and must be designed and built to be a safe place in which to have an accident. We have the know-how today to make the automobile an efficient mechanism in which the human being can decelerate rapidly without injury.

How do we get this car on the road?

Three Ways To Get Safe Cars:

Industry Responsibility

There are at least three ways in which this can come to pass.

The motorcar industry, suddenly imbued with a sense of social responsibility, can agree among its units that they will remove this matter of crash safety from the savage competition which characterizes the routine operations, and will decide upon the safest kind of instrument panel, the most protective bumper, the most efficient arrangement of controls, and will offer these as standard equipment and a standard design on all American automobiles. As knowledge and the art progresses, changes for the better will be made from time to time, but the industry as a whole will see to it that details of design and construction related to crash survival will be the best engineering science can produce and will cease to be playthings in the field of glamour and sales psychology.

The motorcar industry has had nearly thirty years in which to provide us with a safe instrument panel. The late Doctor Claire Straith, of Detroit, wrote me in 1954 that he had been trying since 1934 to get the car-makers to provide a flattened, well padded, nonlethal instrument panel and to eliminate many of the other injury producing items of the car interior. He wrote, "It has been a very uphill business. Although the designers themselves know of these hazards, the sales department is the one that throws up their hands if any mention is made of a possibility of their beautiful car being involved in an accident, and, therefore, they have been very hesitant to remove some of the shiny gadgets from the panel and to crashpad the same."

As late as the summer of 1961, Doctor William Haddon, Jr., addressed the Society of Automotive Engineers as follows:[4]

"A friend of mine, a prominent physician who has long served on one of the committees concerned with this area, saw not many months ago a case of a young child which lost one of its eyes because the vehicle in which it was riding decelerated unexpectedly, with the result that the child was thrown forward, as one knows happens with children riding in cars when cars, as is common, decelerate. The reason why this child lost its eye was that there was placed in the target area—an anticipated target area well known to all of us—a knob. Now the eye, through evolution, or nature, or creation, as each of you will have it, has been very nicely recessed, so that in hitting flat surfaces no damage, unless the impact is overwhelming, results. It has little chance, however, in landing on a protrusion. There *was* a protrusion, placed, by design, literally, at the impact point at which children often hit. That physician, understandably, has been telling many other physicians and anyone that will listen, that that child lost an eye because someone, by design, placed a knob where it would be hit sooner or later by, if not that child's eye, by some other child's eye, or nose, or mouth, or what-have-you. I will leave it to you," said Doctor Haddon to the car makers, "to argue the merits pro and con in this particular issue."

I am sure that almost everyone here knows of similar instances. I know of five doctors' children who lost permanent front teeth by striking the instrument panels in five different panic brake stops.

That Doctor Haddon would need to recount this incident to a motorcar manufacturing audience thirty years after Doctor Straith's notable efforts, or thirteen years after the classic paper by Doctor Fletcher Woodward in 1948[11], indicates to me that we cannot expect the fabulously wealthy motorcar industry independently to accomplish what needs to be done.

The Insurance Approach

The second way is for the insurance companies to take over, as they have in the electric appliance and gas appliance industries.

In February, 1957, a most perceptive article, *How Safe Are The New Cars,* by Paul W. Kearney, appeared in Harper's Magazine. He wrote:

"The whole problem could be solved by the industry itself, with proper policing, and the example is not far to seek. No industry has done a finer job in promoting safety and reliability in its field than the American Gas Association, whose members produce products with a lethal potential at least as great as the automobile. But, by establishing rigorous safety standards, and granting the coveted AGA label only to gas appliances which meet those standards, this industry has commendably compelled its designers to think of safety first and styling second.

"In the realm of electrical appliances and fire protection devices, the pioneer UL symbol of the Underwriter's Laboratories has stood in the same enviable position for an even longer time. Here many different industries participate in paying the costs of brutal, impartial testing by an organization of hard-boiled experts, sponsored by the one group with the most to gain from safety: the insurance companies.

"Isn't this the real answer for the automobile industry? Why shouldn't it and the automobile insurance companies finance an impartial testing laboratory of their own—logically under the auspices of the Society of Automobile Engineers—and make an SAE seal of approval as valuable as the AGA or UL labels, and just as impervious to outside influence?"

It is because the members of the SAE are first of all representatives of active financial institutions, and secondly, professional engineers.

Elsewhere[2], I have described how the Society of Automotive Engineers backed the American Standards Association down when the latter sought to establish a seat belt standard. An industry vice president, speaking as a member of the SAE, threatened that the industry might make three moves: "first, it might resign as a member of the ASA; second, it might reduce its financial support to ASA; or third, it might refuse to participate in standardization projects in its area which might be undertaken over its objection."

No, it will take more than 41,000 dead bodies every year to get crash safety from the Society of Automotive Engineers.

Incidentally, the SAE seat belt standard at the outset was a poor copy of the CAA standard, and even when revised is still inferior to the General Services Administration standard.

The historic way in which the insurance industry has brought safe boilers and safe elevators into being in this country is direct inspection and rating. Obviously, it cannot spend its valuable time in inspection of individual cars in use; but every year, two or three months before the new models appear, and long after style lines have hardened and become finalized, the automobile insurance industry can inspect and rate the crash-safety features. Does this bumper provide protection, or does it assure losses to the insuror? The bumpers on 1963 cars assure maximum damage, in the mildest contacts, to expensive fender, lights, and grilles. Does this frame allow extensive damage to the car interior (and the occupants)? Rate it up, and we can all be sure that next year, this frame will be different. With rigorous up-rating of those features that cause increasing losses to the insurors, the next year's models will likely be better, for the howl that the purchasers of certain makes emit will definitely be heard in Detroit.

In a series of very perceptive papers, W. P. Henderson in The National Underwriter has pled with the insurance industry to recover its legitimate role in the prevention of traffic deaths and injuries.

"In the early days of the automobile, an insurance credit or discount was given to the owner who equipped his car with a bumper. The discount for a front bumper was increased if one was also installed in the rear. These bumpers were sturdy functional and protective units that eliminated or lowered repairs, hence reducing claim costs, and proved to be sound underwriting. This is a classic example of the product improvement influenced by sound underwriting, as bumpers soon became standard equipment.

"In the post-war years bumpers have lost their protective and functional aspect and the beautiful baubles that took their place are adding to instead of reducing insurance cost. . ."

The basic principle on which the insurance business is founded is to charge a rate commensurate with the risk. Medical examinations for life insurance are based solidly on this principle. Automobile casualty companies at long last are doing this for car drivers. *The time is long overdue that they do the same for the car itself.*

The Legislative Approach

The motorcar industry has shown its unwillingness to move ahead in the crash-safety field unless forced to do so by legislation. Threatened legislation by the State of New York forced the car makers to put built-in seat belt attachment points in 1962 cars. For years, the states have passed laws requiring higher and higher standards in lights, window glass, and turning signals. Safety glass was *not* the gift of the industry, as they so often tell us. It was the result of a very expensive law-suit.

A law by California forced the car makers to develop a fume control device, and laws by Wisconsin, Kentucky, Mississippi, Virginia and New York made the car makers decide to put two belts in all 1964 cars. One manufacturer put them in 1963 cars; a leader in the field of safety.

This piece-meal approach by the 50 states has resulted in chaos. A practice in one state is criminal in a bordering state, as fuming tourists know all too well. This confusing and costly situation has led to the formation of the National Committee on Uniform Traffic Laws and Ordinances, 1604 K Street, N.W., Washington 6, D.C. This work was started as long ago as 1926, at which time it was evident that some degree of uniformity of traffic regulation in the United States was sorely needed. Despite formulation of the Uniform Vehicle Code, the disparity in local traffic regulations is still a national disgrace, and the cause of an untold number of traffic accidents.

It is the opinion of this observer that our continuing deaths and injuries on our streets and highways warrant an all-out Federal effort.

I have pointed out that our motorcar dead, of the last sixty years, far exceed all of the war dead of 180 years[12]. This is a national emergency comparable to our aviation posture preceding World War I. In terms of loss of life and property destruction, it is a far greater emergency.

This writer suggests the formation of a National Advisory Committee for motorcar development. This would be a technical committee, employing the best scientific brains available. Its recommendations are given over-powering weight.

The following proposed legislation is offered as a definitive solution to this increasingly serious national disgrace.[1, 9]

Proposed Legislation to Help Solve the Motorcar Death and Injury Problem

A BILL

To reduce loss of life, personal injuries, and property damage resulting from automobile accidents by establishing a Bureau of Motor Vehicle Affairs in the Department of Commerce. This bureau, under an Assistant Secretary of Commerce for Motor Vehicle Affairs, shall have charge of Federal inspections of motor vehicles, and motor vehicle factories and the establishment and enforcement of minimum safety specifications of design and construction to which

Continued on page 672

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Contraindications:
Glaucoma; severe cardiac disease.

Possible Side Actions:
Xerostomia, mydriasis and, occasionally, hesitancy in urination. Theoretically, a curare-like action may occur.

1. Asher, L. M.: The Choice of Anticholinergic Drugs in the Treatment of Functional Digestive Diseases, Amer. J. Dig. Dis. 4:260-275 (April) 1959.

all vehicles manufactured in and imported into the confines of the United States and its possessions must conform.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That it is hereby declared to be the policy of the Government of the United States to play a more vigorous role in reducing the tragic loss of life, personal injury, and property damage which occur annually as a result of automobile accidents on our Nation's highways.

Sec. 2. In order to carry out the policy established in the first section of this Act there is established within the Department of Commerce a Bureau for Motor Vehicle Affairs, under an Assistant Secretary of Commerce for Motor Vehicle Affairs (herein-after referred to as the "Bureau" and "Secretary," respectively). The Secretary shall be appointed by the President, by and with the advice and consent of the Senate.

Sec. 3. The President shall also appoint, by and with the advice and consent of the Senate, a National Advisory Committe for Motorcar Development (hereinafter referred to as the "Advisory Committee") to consist of seventeen members, of whom no more than seven shall be members of the National Academy of Sciences. The Advisory Committee shall at all times have within its membership a physicist, a sociologist, a representative of the General Services Administration, not more than one representative of the motorcar industry, at least one representative of the aircraft manufacturing industry, four Doctors of Medicine (of whom one is a neurosurgeon), four engineers (apart from the representative of the motor-car industry) and such others as the President may feel may be contributory.

Sec. 4 The Functions of the Bureau shall be to:
(1) provide safe motor vehicle transportation for the citizens of this Comonwealth;
(2) provide economical motorvehicle transportation for the citizens, because motor vehicle transportation for individuals has long since ceased to be a luxury item, and basic individual transportation of an efficient, economical nature is a fundamental need and right of the citizens of the modern Commonwealth;

(3) integrate the development of the motorcar with the development of that factor without which it cannot operate efficiently, our public roads.

Sec. 5. It shall be the duty of the Secretary, pursuant to Sec. 4, (1) above to require the motorcar manufacturers to incorporate in their products those designs and devices which the Advisory Committee by a majority vote of its entire membership shall recommend. These designs and devices shall appear and be maintained in all motorcars produced after not longer than twenty (20) months of the vote of the Advisory Committee. The Bureau shall maintain in every factory Federal inspectors to the number deemed necessary to enforce the provisions of this Act. Every motor vehicle shall bear the Bureau mark of approval, a non-corrodible metal plate, bearing the manufacture's serial number, durably attached, under the supervision of the Federal inspector, to the motorcar in a conspicuous place. If the Secretary at any time believes that a manufacturer is willfully or negligently not conforming to the provisions of this Act, he may halt, by Federal injunction, the manufacturing processes of this manufacturer. A levy for the costs of the inspectors' salaries and inspection processes in each factory is to be made against the factory, and paid into the Treasury of the United States quarter-annually. It is provided that the members of the Advisory Committee, as such, shall serve without compensation, except that travel and accomodations of the first class shall be provided for all those members who are not Federal employees, in which case travel and accomodations shall be provided by the Service of which the committee member is an employee. The Advisory Committee shall meet regularly twice a year, with such special or emergency meetings as shall be deemed necessary by either the Chairman of the Advisory Committe (who is to be elected by the members annually) or the Secretary. An Executive Committee of the Advisory Committee shall be formed consisting of seven members charged with administration of the affairs of the Advisory Committee, and general supervision of all arrangements for research.

Sec. 6. The Congress recognizes (from the experience of the National Advisory Committee for Aeronautics, the Civil Aeronautics Administration, and the Civil, Aeronautics Board) that independent research may be demanded by the necessities of the problem, no, perhaps, to the extent that has been required by the NACA, and CAA, but to the extent needed to carry out the purposes of this Act.
Sec. 7. Such appropriations as are necessary to cary out the provisions of this Act are hereby authorized.

Respectfully submitted,
Horace E. Campbell, M.D.

I am sure that some are thinking, "but we already have the President's Committee for Traffic Safety. Surely it is the best, and why have another?"

The President's Committee is a "public support" medium, by character. It is privately financed and is beholden to the donors, just as is the American Standards Association. In its present constitution it cannot and will not involve itself in any way in the matter of vehicle design and construction, the definitive factor in our traffic death and injury problem.

Belonging to the Patrick Henry School, I believe that we must solve the traffic death and injury problems. The recent thalidomide affair should have some lessons for us in traffic safety.

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KSMA OFFICERS

1962

1963

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Vice President—Central

Hugh Mahaffey, M.D.
Vice President—Eastern

Joseph R. Miller, M.D.
Vice President—Western

President-Elect

George P. Archer, M.D., Prestonsburg

A former delegate to the AMA and recipient of the KSMA Distinguished Service Award in 1961, Doctor Archer will be installed as president of the Kentucky State Medical Association during the 1963 Annual Meeting on Wednesday evening, Sept. 24.

After graduating from the University of Louisville Medical School in 1941, he interned for a year at St. Anthony Hospital, Oklahoma City. Following his internship he served in the U.S. Army Air Force for four years, receiving his discharge with the rank of major in 1946.

Doctor Archer spent a year in private practice in Paintsville and as part-time Johnson County Health officer, before settling in private practice in Prestonsburg.

Since entering practice, he has served medicine in many capacities. He is a past president of the Floyd County Medical Society and has been chairman of the Floyd County Board of Health since 1954. He has served on numerous KSMA committees.

In 1958 he was appointed delegate to the AMA to fill out the term of the late Clark Bailey, M.D. Re-elected an AMA delegate in 1960, he represented the KSMA on the Reference Committee on Industrial Medicine and the Insurance Committee. At each AMA annual and clinical sessions he appeared on behalf of "free choice of physicians" resolutions. In 1961 he became the first chairman of KEMPAC.

He helped form the Kentucky Chapter of the American Academy of General Practice and was its first secretary. In 1958 he was KAGP vice president. Doctor Archer was also instrumental in forming the first Eastern Kentucky Hospital Council and was one of its first officers.

He was appointed medical representative on the University of Louisville Development program in 1959, appointed to the White House Committee on Aging by Governor Bert Combs in 1960, and in 1962 appointed to the Kentucky Hospital Council.

Named one of three outstanding young Kentuckians by the Jaycees in 1949 for his civic work, he has since been chairman of the Prestonsburg School Board, president and member of the Board of Directors of the Prestonsburg School Board, president and member of the Board of Directors of the Prestonsburg Kiwanis Club, and in 1961 was elected mayor of Prestonsburg. He is also active in Boy Scout work and church affairs.

His outstanding record of service to medicine and his community, coupled with his personal qualities of leadership, dedication, and integrity made him the natural choice as president-elect.

VICE PRRESIDENT, CENTRAL

Alfred O. Miller, M.D., Louisville

An Assistant Professor of Radiology at the University of Louisville School of Medicine, Doctor Miller has engaged in the private practice of radiology in Louisville since 1948. He received his M.D. from U. of L. in 1939. Doctor Miller is a Diplomate of the American Board of Radiology, a member of the American College of Radiology, and of the American Roentgen Ray Society, and a member and a past counselor for Kentucky of the American College of Radiology. He has also served as a past counselor for Kentucky for the Radiological Society of North America. He is now chairman of the Radiologist-Manufacturers Committee of the Radiologic Society of North America.

VICE PRESIDENT, EASTERN

Hugh Mahaffey, M.D., Richmond

A past chairman of the Board of Trustees of the Kentucky State Medical Association, Doctor Mahaffey served as a Trustee (then councilor) from the Eleventh Trustee District for several years, having been first elected to the Board in 1951. He has served on the KSMA executive committee, in addition to his many other activities within County and State Associations. Doctor Mahaffey, a member of the Kentucky Surgical Society and the Kentucky Chapter, American College of Surgeons, was graduated in 1928 from the University of Louisville School of Medicine. He is a member of the staff of the Pattie A. Clay Infirmary in Richmond and the Berea College Hospital, Berea.

VICE PRESIDENT, WESTERN

Joseph R. Miller, M.D., Benton

A native Kentuckian, Doctor Miller was born in New Providence. Following his graduation from the University of Louisville School of Medicine in 1942, he took his internship training at Baroness Erlanger Hospital, Chattanooga, Tenn., and has attended two summer sessions at Cook County Graduate School of Medicine. He served three years in the medical corps and was honorably discharged with the rank of major. Active in medical activities, he was elected president of the Marshall County Medical Society on three different occasions. Doctor Miller has been a director of the First District of the Kentucky Academy of General Practice.

KSMA Secretary and Treasurer

SECRETARY

Woodford B. Troutman, M.D., Louisville

Doctor Troutman, who was KSMA treasurer for 12 years from 1946 to 1958, will complete his first full five-year term as secretary this year. He was elected secretary in 1958 after serving for two years as interim secretary. After his graduation from the University of Louisville School of Medicine in 1921, he took his internship training at McKeesport Hospital, Pennsylvania, and Bellevue Hospital, New York City. A cardiologist, Doctor Troutman also studied in Vienna, London and Edinburgh. He is certified by the American Board of Internal Medicine and is a member of the American College of physicians, American Heart Association and the American Society of Internal Medicine.

TREASURER

Delmas M. Clardy, M.D., Hopkinsville

A past president and secretary of the Christian County Medical Society, Doctor Clardy had served as a KSMA delegate for 18 years and a district councilor (now Trustee) for six when he was elected treasurer by the House of Delegates in 1958. He is also president of the Kentucky Surgical Society. In 1932 he received his medical degree from the University of Louisville School of Medicine. Doctor Clardy is a native of Tennessee and during World War II was chief of the surgical section of the 187th General Hospital in the European Theater. A fellow of the American College of Surgeons, he limits his practice to general surgery. Doctor Clardy is also a member of the southeastern Surgical Congress.

KSMA Journal Editors

EDITOR

Sam A. Overstreet, M.D., Louisville

KSMA's Centennial president in 1950-51, Doctor Overstreet has served as editor of the Journal for the past five years and before that was scientific editorial editor. A 1923 graduate of the University of Louisville School of Medicine, he is a former speaker of the KSMA House of Delegates and a former governor of the Kentucky Chapter, American College of physicians. An internist, he was recently named a member of the State Board of Health by Governor Combs. He was president of the Jefferson County Medical Society in 1947.

ASSOCIATE EDITOR

Walter S. Coe, M.D., Louisville

Doctor Coe was named associate editor of the KSMA Journal in 1962 after serving as Book Review editor for a number of years. A graduate of the University of Louisville School of Medicine in 1943, he is now an associate professor of medicine at U. of L. He is a former president of the Louisville and Jefferson County Heart Association and director of the Kentucky Heart Association. Past president of the Louisville Society of Internal Medicine, Doctor Coe is now president-elect of the Kentucky Society of Internal Medicine.

AMA Delegates

Robert C. Long, M.D., Louisville

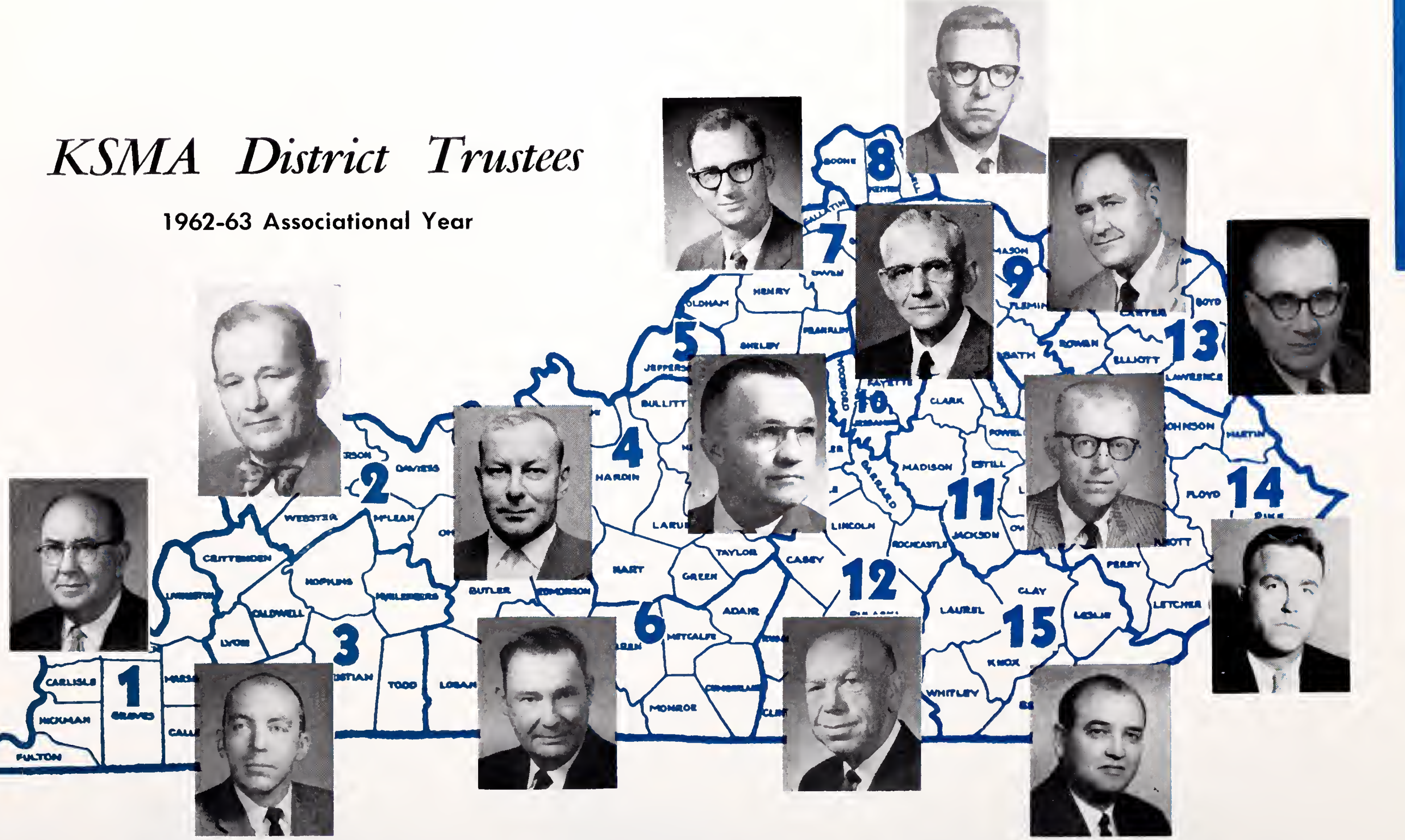
Doctor Long, who has been active in organized medical activities since he entered practice in 1947, was elected to the AMA Board of Trustees at the annual AMA meeting in Atlantic City in June. An obstetrician and gynecologist, he graduated from the University of Louisville School of Medicine in 1940. He has been KSMA delegate to the AMA since 1956 and has served on the AMA's National Speakers Bureau and as chairman of its Reference Committee on Legislation and Public Relations.

J. Vernon Pace, M.D., Paducah

Recently elected a councilor of the Kentucky Chapter, American College of Surgeons, Doctor Pace is a 1921 graduate of the Vanderbilt University School of Medicine, Nashville. A former chairman of the old KSMA Council, he was an alternate delegate to the AMA before being elected a delegate in 1961. He has served as chairman of the old KSMA Council, and was an alternate delegate to the AMA before being elected a delegate in 1961.

KSMA District Trustees

1962-63 Associational Year



1. O. LEON HIGDON, Paducah
2. HOWELL J. DAVIS, Owensboro
3. GABE A. PAYNE, JR., Hopkinsville
4. DIXIE E. SNIDER, Springfield
5. CARLISLE MORSE*, Louisville
6. JOHN P. GLENN, Russellville
7. DONALD CHATHAM **, Shelbyville
8. DEXTER MEYER, Covington
9. MITCHELL B. DENHAM, Maysville
10. DOUGLAS E. SCOTT, Lexington
11. HUBERT C. JONES *, Berea
12. THOMAS O. MEREDITH, Harrodsburg
13. CLYDE C. SPARKS, Ashland
14. WILLIAM C. HAMBLEY, Pikeville
15. KEITH P. SMITH†, Corbin

†Chairman of the Board
**Members of the Executive Committee*
***Serving Interim Term*

AMA Delegates

Wyatt Norvell, M.D., New Castle

A former chairman of the KSMA Board of Trustees and past vice-president of KSMA (Eastern), Doctor Norvell was elected delegate to the AMA at the 1962 Annual Meeting. He has also served the KSMA as Seventh District trustee and as chairman of the Committee on Rural Health. Doctor Norvell is a former director of the KAGP and a former president of the Henry County Medical Society. A 1941 graduate of the University of Louisville School of Medicine, he served in the China-Burma-India Theater during World War II, received his discharge with the rank of Major. He is listed in "Who's Who in the South and Southwest."

New Trustee

FIRST DISTRICT

O. Leon Higdon, M.D., Paducah

Doctor Higdon, a native of Graves County, served as vice president of the KSMA in 1956 and was alternate delegate to the American Medical Association in 1954-5. He graduated from the Cincinnati, Ohio, Eclectic Medical College with an M.D. degree in 1929 and took his training in obstetrics and gynecology at the University of Pennsylvania Medical Graduate School. He is a delegate to the KSMA and has been especially active in the Association in the fields of insurance and legislation. Doctor Higdon is a fellow of the American College of Obstetricians and Gynecologists.

New Trustees

THIRD DISTRICT

Gabe A. Payne, Jr., M.D., Hopkinsville

A past president of the Christian County Medical Society, Doctor Payne has served as a Delegate to the KSMA and in 1958 was a member of the Medical Mission Team sponsored by the Baptist World Alliance on a round-the-world tour of medical mission installations. A 1943 graduate of Vanderbilt University School of Medicine, Doctor Payne, a pediatrician, has been active in local civic and church affairs, as well as in organized medicine. In addition to KSMA, he is a member of the AMA, the Kentucky Pediatric Society, and is a Diplomate of the American Board of Pediatrics.

SEVENTH DISTRICT

Donald Chatham, M.D., Shelbyville

A native of Louisville, Doctor Chatham received his M.D. degree from the University of Louisville School of Medicine in 1952. He took his internship training at Louisville General Hospital and has been in general practice in Shelbyville for the past ten years. A past president of the Shelby-Oldham-Henry Medical Society, he is also active in church and civic affairs. He is now serving as alumni president of Georgetown College.

Election of Trustees

Trustees for six KSMA Districts will be elected by the House of Delegates at its second session on Wednesday, September 25. Nominations will be made at a caucus of the delegates from each district immediately after the first session of the House on September 23. The committee will report its nominees at the close of the first scientific session on Tuesday, September 24. Further nominations may be made from the floor at the second meeting of the House on September 25. The six districts are: **Fifth District** (incumbent Carlisle Morse, M.D., Louisville); **Sixth District** (incumbent John P. Glenn, M.D., Russellville); **Seventh District** (incumbent Donald Chatham, M.D., Shelbyville); **Eighth District** (incumbent Dexter Meyer, M.D., Covington); **Eleventh District** (incumbent Hubert C. Jones, M.D., Berea); **Fifteenth District** (incumbent Keith P. Smith, M.D., Corbin). Doctor Meyer and Doctor Jones have served only one full term and are eligible for reelection. Doctor Chatham is serving an unexpired term ending in 1964 and is eligible for reelection. Biographical information on new trustees elected in 1962 appears above.

see map on preceding page

Officers of the KSMA House of Delegates

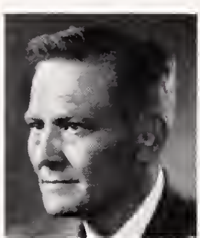
SPEAKER
Garnett Sweeney, M.D., Liberty

Doctor Sweeney, who had served as vice speaker since 1959, was elected speaker by the House of Delegates at the 1962 meeting.

He was chairman of the KSMA Council (now the Board of Trustees) before becoming vice speaker. At that time he had just completed his second term on the Council. A graduate of the University of Louisville School of Medicine in 1939, he took his internship training at Charity Hospital, New Orleans, La. He is a former chairman of the KSMA Committee on Medical Education. Doctor Sweeney was president of the KAGP in 1954 and has been in general practice in Liberty since 1940.

VICE SPEAKER
George F. Brockman, M.D., Greenville

Named vice speaker of the KSMA House of Delegates in 1962, Doctor Brockman has served KSMA in numerous capacities.



He was appointed delegate to the AMA in April 1961 and served through December of that year. As chairman of the KSMA Building Committee, he helped plan and took charge of construction of the new Association headquarters building. Doctor Brockman graduated from the University of Louisville Medical School in 1935 and interned at Louisville General Hospital. He has been in private practice in Greenville since 1946 and is currently secretary of the Muhlenberg County Board of Health.

KSMA Delegates

ADAIR
J. C. Salato, Columbia

ALLEN
Earl Oliver, Scottsville

ANDERSON
Boyd Caudill, Lawrenceburg

BALLARD
Jesse M. Hunt, Jr., Wickliffe

BARREN
Eugene L. Marion, Glasgow

BATH
Robin A. Byron, Owingsville

BELL

BOONE
Philip Schworer, Florence

BOURBON
R. J. Wever, Paris

BOYD
Walter L. Cawood, Ashland
Guy C. Cunningham, Ashland

BOYLE
Chris S. Jackson, Danville

BRACKEN
J. M. Stevenson, Brooksville

BREATHITT
Robert E. Cornett, Jackson

BRECKINRIDGE
James G. Sills, Hardinsburg

BULLITT

BUTLER
John Burris, Morgantown

CALDWELL
N. H. Talley, Princeton

CALLOWAY
Hugh L. Houston, Murray

CAMPBELL-KENTON
Carl J. Brueggeman, Covington
Thomas Huth, Newport
Donald Janney, Covington
R. Charles Smith, Newport
Richard Allnutt, Covington
Paul Klingenberg, Covington

CARLISLE

CARROLL
Edgar S. Weaver, Carrollton

CARTER
J. Watts Stovall, Grayson

CASEY
Lewis Wesley, Liberty

CHRISTIAN
Guinn S. Cost, Hopkinsville
Norman T. Shepherd, Hopkinsville

CLARK

CLAY
W. E. Becknell, Manchester

CLINTON
Ernest A. Barnes, Albany

CRITTENDEN
R. M. Brandon, Marion

CUMBERLAND
Jack L. Beck, Burkesville

DAVIESS
L. C. Dodson, Owensboro
B. H. Warren, Owensboro
W. W. Hall, Owensboro

EDMONSON

ELLIOTT
John F. Green, Sandy Hook

ESTILL
S. G. Marcum, Irvine

FAYETTE
Carl Fortune, Lexington
W. L. Boswell, Lexington
Robert D. Shepard, Lexington
Harvey Chenault, Lexington
N. L. Bosworth, Lexington
M. R. Gilliam, Lexington
L. E. Hurt, Lexington
E. D. Pellegrino, Lexington
J. H. Saunders, Lexington
E. C. Strode, Lexington

FLEMING
R. W. Fidler, Flemingsburg

FLOYD
Russell L. Hall, Prestonsburg

FRANKLIN
John Stewart, Frankfort

FULTON
Robert T. Peterson, Fulton

GALLATIN
J. E. Esteves, Warsaw

GARRARD
Paul Lett, Lancaster

GRANT
F. R. Scroggins, Dry Ridge

GRAVES
John Reed, Mayfield

GRAYSON

GREEN
J. W. Miller, Greensburg

GREENUP
Billie Riddle, South Shore

HANCOCK

HARDIN
Charles F. Long, Elizabethtown

HARLAN
E. M. Howard, Harlan
David McL. Greeley, Harlan

HARRISON
H. H. Moody, Cynthiana

HART

HENDERSON
Kenneth M. Eblen, Henderson

HENRY
Shelby Hicks, New Castle

HICKMAN

HOPKINS
Loman Trover, Madisonville
F. A. Scott, Madisonville

JACKSON

JEFFERSON
C. Melvin Bernhard, Louisville
Ralph M. Denham, Louisville
James B. Douglas, Louisville
Robert L. McClendon, Louisville
William E. Oldham, Louisville
B. Frank Radmacher, Jr., Louisville
Henry G. Saam, Louisville
George I. Uhde, Louisville
Rudolph Vogt, Louisville
John D. Allen, Louisville
Paul J. Ross, Louisville
James Davis, Louisville
A. L. Goodman, Louisville
John Hemmer, Louisville
Richard Mardis, Lousiville
Herman Moore, Louisville
James Riley, Louisville
John Robbins, Louisville
Bernard Schoo, Louisville
Sam Weakley, Louisville
Frank A. Bechtel, Louisville
Elbert G. Christian, Louisville
Morgan R. Colbert, Louisville
William C. Durham, Louisville
Rudy J. Ellis, Louisville
Hollis Johnson, Louisville
George F. McAuliffe, Louisville
Samuel M. Smith, Louisville
Robert C. Tate, Louisville
Edward Warrick, Jr., Louisville

JESSAMINE
J. S. Williams, Nicholasville

JOHNSON
James W. Archer, Paintsville

KNOTT
M. F. Kelley, Hindman

KNOX
H. L. Bushey, Barbourville

LARUE

LAUREL
E. C. Seeley, London

LAWRENCE
Forest F. Shely, Louisa

LEE
E. J. Broaddus, Beattyville

LESLIE

LETCHER
J. B. Tolliver, Whitesburg

LEWIS

LINCOLN
H. I. Frisbie, Stanford

LIVINGSTON

LOGAN
W. R. Byrne, Russellville

LYON
M. H. Moseley, Eddyville

McCRACKEN
R. M. Wooldridge, Paducah
W. E. Sloan, Paducah
G. H. Widener, Paducah

McCREARY
M. A. Winchester, Whitley City

McLEAN
W. G. Edds, Calhoun

MADISON

MAGOFFIN

MARION

MARSHALL
J. R. Miller, Benton

MARTIN

MASON

MEADE
George E. Clark, Brandenburg

MENIFEE
D. L. Graves, Frenchburg

MERCER
T. C. VanArsdall, Harrodsburg

METCALFE
P. D. Hitchcock, Edmonton

MONROE
C. A. Crabtree, Tompkinsville

MONTGOMERY
Robert Salisbury, Mt. Sterling

MORGAN
Morris L. Peyton, West Liberty

MUHLENBERG
R. E. Davis, Central City

NELSON
Emmett W. Wood, Bardstown

NICHOLAS
W. R. Kingsolver, Carlisle

OHIO

OLDHAM
E. G. Houchin, LaGrange

OWEN
O. A. Cull, Owenton

OWSLEY
Mildred B. Gabbard, Booneville

PENDLETON
Robert L. McKenney, Falmouth

PERRY
Mary Fox, Hazard

PIKE
Ballard Cassady, Pikeville

POWELL
S. T. Scrivner, Stanton

PULASKI
A. L. Cooper, Somerset
Robert F. Long, Somerset

ROBERTSON

ROCKCASTLE

ROWAN

RUSSELL
Marshall M. Lawrence, Jamestown

SCOTT
J. C. Cantrill, Georgetown

SHELBY
M. D. Klein, Shelbyville

SIMPSON
L. F. Beasley, Franklin

SPENCER
W. K. Skaggs, Taylorsville

TAYLOR
W. R. Mann, Campbellsville

TODD

TRIGG
Elias N. Futrell, Cadiz

TRIMBLE
Carl Cooper, Bedford

UNION

WARREN
Paul Parks, Bowling Green
Martin Wilson, Bowling Green

WASHINGTON
H. B. Simms, Springfield

WAYNE
Robert B. Breeding, Monticello

WEBSTER
Earl Atherton, Clay

WHITLEY
Harold Barton, Corbin

WOLFE
Paul F. Maddox, Campton

WOODFORD
Ben F. Roach, Midway

Open Meeting Planned Monday by Nominating Committee

Members wishing to confer with the KSMA Nominating Committee will have an opportunity to do so at an open meeting scheduled following the close of the first session of the House of Delegates on Monday morning, September 23.

Final recommendations of the committee will be reported at the end of the first scientific session on Tuesday morning, September 24. Other nominations may be made from the floor at the House of Delegates meeting on Wednesday evening, September 25. At the close of the second session on Wednesday the House will vote on these nominees.

Members of the nominating committee headed by Loman C. Trover, M.D., Madisonville, are Ballard Cassady, M.D., Pikeville; James B. Douglas, M.D., Louisville; Carl Fortune, M.D., Lexington; and Gabe A. Payne, M.D., Hopkinsville.

Reference Committee Activity

All officers' and committee reports and resolutions will be referred to one of seven reference committees **at the first meeting of the KSMA House of Delegates at 9 a.m. on Monday, September 23,** by Speaker Garnett J. Sweeney, M.D., Liberty. Reference committees will meet at **2 p.m. Monday, September 23, on the third floor of the Phoenix Hotel.** Members of the committees should meet for briefing sessions at 1:45 p.m. in Reference Committee Room No. 1. **Any KSMA member wishing to testify on any resolution or report is urged to be present at 2 p.m.** The open hearings will last at least an hour in order to permit all who wish to speak to be heard. The committees will go into executive session to study the reports and review the testimony given at the hearings, following the open hearings. The committees' recommendations will be made for presentation at the final session of the House in the ballroom of the Phoenix on Wednesday night, September 25. Reference committees appointed by Doctor Sweeney to serve during the 1963 session follow:

1963 Reference Committee Appointments

REFERENCE COMMITTEE NO. 1

Reports of Officers and Board of Trustees

Ballard W. Cassady, M.D., Pikeville, Chairman
Walter R. Byrne, M.D., Russellville
Guy C. Cunningham, M.D., Ashland
Paul J. Ross, M.D., Louisville
George H. Widener, Jr., M.D., Paducah

REFERENCE COMMITTEE NO. 2

Scientific Assembly and Medical Education

Kenneth M. Eblen, M.D., Henderson, Chairman
Guinn S. Cost, M.D., Hopkinsville
Ralph M. Denham, M.D., Louisville
Paul H. Klingenberg, M.D., Covington
Paul M. Reed, M.D., Mayfield

REFERENCE COMMITTEE NO. 3

Legislative Activities

E. C. Seeley, M.D., London, Chairman
James W. Miller, M.D., Greensburg
Bernard J. Schoo, M.D., Louisville
Frederick R. Scroggins, M.D., Dry Ridge
James G. Sills, M.D., Hardinsburg

REFERENCE COMMITTEE NO. 4

Public Service and Allied Professions

Paul J. Parks, M.D., Bowling Green, Chairman
Richard A. Allnutt, M.D., Covington
James W. Archer, M.D., Paintsville
N. L. Bosworth, M.D., Lexington
Paul E. Lett, M.D., Lancaster

REFERENCE COMMITTEE NO. 5

Medical Service

Russell L. Hall, M.D., Prestonsburg, Chairman
John C. Burris, M.D., Morgantown
Robert L. McClendon, M.D., Louisville
Lewis Wesley, M.D., Liberty
Philip Schworer, M.D., Florence

REFERENCE COMMITTEE NO. 6

Constitution and Bylaws; Special Committees

M. Randolph Gilliam, M.D., Lexington
John D. Allen, Jr., M.D., Louisville
James L. Beck, M.D., Burkesville
John P. Stewart, M.D., Frankfort
Nathaniel H. Talley, Jr., Princeton

REFERENCE COMMITTEE NO. 7

Miscellaneous

James M. Riley, Jr., M.D., Louisville
Harold B. Barton, M.D., Corbin
L. F. Beasley, M.D., Franklin
W. Gerald Edds, M.D., Calhoun
Joseph H. Saunders, M.D., Calhoun

CREDENTIALS COMMITTEE

Harvey Chenault, M.D., Lexington, Chairman
Frank A. Bechtel, M.D., Louisville
Norma T. E. Shepherd, M.D., Hopkinsville

Annual Meeting Special Features

• **SCIENTIFIC SESSIONS,** featuring panel discussions and scientific presentations, and highlighted by color television, are scheduled daily on Tuesday, Wednesday, and Thursday, September 24, 25, and 26.

• **THE HOUSE OF DELEGATES,** the policy-making body of the KSMA, will hold two sessions during the 1963 Annual Meeting—one on Monday, at 9 a.m., September 23, and the final session on Wednesday evening, September 25. Officers for 1963-64 will be elected at the Wednesday night session.

• **FOURTEEN SPECIALTY GROUPS** will meet during the annual meeting, three on Tuesday morning, September 24; one on Tuesday afternoon; six on Wednesday afternoon; one Thursday morning; and three on Thursday afternoon. All KSMA members are invited to attend these sessions, which will feature outstanding guest-speakers from various fields of medicine.

• **THE PRESIDENT'S LUNCHEON,** featuring an address by Henry M. Johnson, D.D., Minister of Education at the First Methodist Church in Fort Worth, Texas, will be held in the Gold Room of the Lafayette Hotel at noon on Wednesday, September 25. "How to Keep from Going Nuts in a Nutty World," will be the topic of Doctor Johnson's address. Presentation of the three top KSMA awards will be another highlight of the luncheon.

• **CLOSED CIRCUIT COLOR TELEVISION** presentations will be interspersed throughout the General Scientific Sessions of the Annual Meeting. The showings, which will originate from the new University of Kentucky Medical Center, will be used in conjunction with various panel discussions and will be for the purpose of presenting case studies and other pertinent information.

• **ALUMNI REUNIONS** will be held this year by five year classes of the University of Louisville School of Medicine. The ten classes holding reunions will start with the class of 1933, which will be celebrating its 50th Anniversary. A cocktail party for alumni will also be given by the U. of L. medical faculty in honor of J. Murray Kinsman, M.D., former dean of the medical school and now a vice-president of U. of L.

Official Call

KSMA Annual Meeting

To the officers and members of the component county societies of the Kentucky State Medical Association.

Meeting Place

The Annual Meeting of The KSMA will convene at the Phoenix Hotel, Lexington, on Tuesday, Wednesday, and Thursday, September 24, 25, and 26. The general session will be called to order at 9 a.m. Tuesday.

The House of Delegates

The first regular session of the House of Delegates will convene at 9 a.m. Monday, September 23. The second regular session will begin at 7 p.m., Wednesday, September 25. Both sessions will be held in the Crystal Ballroom of the Phoenix Hotel.

Registration

The registration desk will open in the Convention Hall of the Phoenix Hotel at 8 a.m. on Monday, September 23, and at 5:30 p.m. on Wednesday, September 25. It will be open in the scientific assembly hall of the Phoenix from 8 a.m. to 5 p.m. on Tuesday, September 24, Wednesday, September 25; and Thursday, September 26.

Texan to Address Pres. Luncheon at Hotel Lafayette Wednesday

"How to Keep from Going Nuts in a Nutty World" is the topic which Henry M. Johnson, Ph.D., D.D., Fort Worth, Tex., will discuss at the 1963 President's Luncheon.

The luncheon will be held in the Gold Room of the Lafayette Hotel, Lexington, at noon on Wednesday September 25.

Minister of education at the First Methodist Church in Fort Worth, Doctor Johnson was head of the Department of Psychology and Religious Education in Atlanta for 15 years. He is the author of numerous articles and has gained national renown as an after-dinner speaker and lecturer.

He received his Ph.D. from Yale and his D.D. from Kentucky Wesleyan. A native of Kentucky, he was principal and athletic coach at Carrollton High School after his graduation from Wesleyan with a Bachelor's Degree and six athletic letters.

KSMA president David M. Cox, M.D., Louisville, will preside at the luncheon. William H. Bizot, M.D., Louisville, chairman of the KSMA Awards Committee, will present the 1963 awards. Irvin Lunger, Ph.D., president of Transylvania College will deliver the invocation.

Annual Meeting

Woman's Auxiliary to the KSMA

Monday, September 23

Program Prevue: 4:00 p.m. Red Room, Lafayette Hotel (County Presidents and Program Chairmen).

Tuesday, September 24

Pre-convention Board Breakfast: 8:00 a.m. Red Room, Lafayette Hotel (subscription). All state officers, councilors. state committee chairmen, county auxiliary presidents and the three immediate past presidents are urged to attend.

Formal opening of Convention: 10:00 a.m., Gold Room, Lafayette Hotel. Luncheon: 12:30 p.m., Gold Room, honoring past presidents, members-at-large, and distinguished guests. Formal Convention Session: 2:00 p.m., Gold Room. Historic Tours of the Bluegrass: 3:45 p.m. (Leaving entrance Lafayette Hotel).

Wednesday, September 25

SWAP Breakfast: 8:00 a.m., Red Room. All outgoing/incoming state officers, chairmen, and councilors are urged to attend. Formal convention session: 9:15 a.m., Georgian Room. Luncheon honoring Mrs. William H. Evans, President-Elect, Woman's Auxiliary AMA, at Lexington Country Club. Transportation from Phoenix Hotel entrance 12:15 p.m. Afternoon at the Lexington Trotting Track.

Gavel Dinner: 7:30 p.m. (Past State Presidents)

Thursday, September 26

Post-convention Board Breakfast: 8:45 a.m., Red Room

Special Awards To Be Given At President's Luncheon

Presentation of three KSMA awards will be a feature of the 1963 President's Luncheon in the Gold Room of the Lafayette Hotel on Wednesday noon, September 25, according to William H. Bizot, M.D., Louisville, chairman of the Awards Committee.

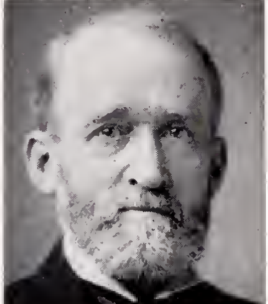
Physicians will be nominated by the awards committee as recipients of the Distinguished Service Medal, which Mitchel B. Denham, M.D., Maysville, won last year, and for the Outstanding General Praqctitioner Award which went to John P. Walton, M.D., Central City in 1962. The R. Haynes Barr Award for a layman who is active in the public health field will be given again this year. 1962 winner was Miss Dorcas Ruthenberg, Louisville.

Selections of awards recipients will be made by the House of Delegates on Monday morning, September 23, on the basis of the Awards Committee's nominations and any nominations from the floor.

Members of the awards committee with Doctor Bizot are: Neal Calhoun, M.D., Madisonville; Earl W. Christensen, M.D., Lexington; Ollie Emerine, M.D., Elizabethtown; Richard H. Weddle, M.D., Somerset.

1963 Annual Meeting To Honor 1882 Pres. J. W. Holland

The 1963 Kentucky State Medical Association Annual Meeting will be officially titled The J. W. Holland Memorial Meeting in tribute to the 1882 President of the KSMA.



The tradition of honoring a former president of KSMA or a distinguished Kentucky physician each year at the Annual Meeting was begun in 1935.

A biography of Doctor Holland, written by KSMA Historian Emmet F. Horine, M.D., of Brooks, will appear in the program booklet which will be distributed at the meeting September 24, 25, and 26.

1881 President Lyman B. Todd was honored at last year's meeting.

Ten U. of L. Alumni Reunions Set for Annual Meeting

Medical School Alumni of ten graduating classes of the University of Louisville will hold their traditional class reunions during the 1963 KSMA Annual Meeting, according to Hoyt D. Gardner, M.D., Louisville, president of the Medical Alumni Association.

A cocktail party honoring former Dean J. Murray Kinsman, M.D., for alumni, their guests, and members of KSMA, will be given by the medical faculty at 6 p.m. Tuesday, September 24, in the Georgian Room of the Lafayette Hotel. Following the cocktail hour, a banquet for all alumni and KSMA members will be held at 7 p.m. in the Gold Room of the Lafayette.

Hugh H. Hussey, M.D., past Dean of Georgetown University School of Medicine, now Director of Scientific Activities Division of the AMA, will give the main address at the banquet. William Furnish, M.D., Professor of Biology at U. of L., will also speak. An interesting program, including recognition of outstanding class attendance of the reunion, is planned for the graduates.

Tickets for the banquet may be obtained at the U. of L. booth at the Phoenix during the annual meeting, or from the Alumni Office at the University of Louisville.

For additional information about your class reunion, please contact your chairman. Les Shively, director of Alumni Relations at U. of L., has released the following list of the classes holding reunions and their chairmen:

1913 To be announced
1918 To be announced
1923 To be announced
1928 Charles Johnson, M.D., Russell
1933 Tom Blake, M.D., St. Albans, W. Va.
1938 George Greene, M.D., 1307 S. Limestone, Lexington
1943 Esten S. Kimbel, M.D., 220 Steele, Frankfort
1948 John McGowan, M.D., 1825 Fielden Dr., Lexington; and James L. Stambaugh, Jr., M.D., Lexington Clinic, Lexington
1953 George M. Gumbert, Jr., M.D., 2101 Nicholasville Rd., Lexington
1958 Morris M. Weiss, Jr., M.D., Brown Building, Louisville

KSMA Official Historian

Emmet Field Horine, M.D., Brooks

Doctor Horine, a 1907 graduate of the University of Louisville School of Medicine, has been the official historian of the Kentucky State Medical Association for many years. Each year he writes the biographical information on the KSMA past president in honor of whom the meeting is named.

Now retired from active practice, Doctor Horine has worked in cooperation with the building committee on the use of old medical literature and souvenirs to be placed in the small museum which will eventually be housed in the new Headquarters office. In 1951 Doctor Horine wrote a history of the Association in connection with the Centennial celebration.

Doctor Kinsman To Be Honored At Faculty Party for Alums

J. Murray Kinsman, M.D., for 14 years dean of the U. of L. School of Medicine, and now a vice-president of the University, will be the honored guest at the annual cocktail party for medical school alumni given by the medical faculty during the KSMA Annual Meeting, according to information recently released.

The party will be held this year at 6 p.m. Tuesday, September 24, in the Georgian Room of the Lafayette Hotel, immediately preceeding the Alumni Banquet.

Although both the cocktail party and banquet are given for the alumni of U. of L., all KSMA members are cordially invited to attend.

REGISTRATION

Please register at the Registration Booth in the south end of the Convention Hall at the Phoenix Hotel as soon as you are able. Hours are from 8 a.m. to 5 p.m. (EST), Tuesday, Wednesday and Thursday, September 24, 25, and 26.

You are requested to wear your badges at all times while in the Hotel.

Episcopal M.D.'s to Hold Communion

A Corporate Communion for Episcopal Physicians will be held during the Annual Meeting of the Kentucky State Medical Association Annual Meeting. The Reverend Dudley Barksdale, Episcopal Chaplain to the University of Kentucky, will celebrate the Communion, to be held at 7 a.m., Wednesday, September 25, at the University of Kentucky Hospital Chapel. A Dutch Treat Breakfast will follow in the Hospital Cafeteria. Medical Students and their families are invited to participate.

'63-'64 Officers to be Elected By House on September 25

KSMA Officers for the 1963-64 year will be elected at the second session of the KSMA House of Delegates on Wednesday night, September 25. Offices to be filled at that time are:

President-Elect (Western) one year

Vice Presidents (Central) one year
(Eastern) one year
(Western) one year

Secretary: three years (incumbent Woodford B. Troutman, M.D., Louisville)

Treasurer: three years (incumbent Delmas M. Clardy, M.D., Hopkinsville)

Delegates to the AMA: two years (incumbents J. Vernon Pace, M.D., Paducah; Wyatt Norvell, M.D., New Castle)

Alternate Delegates to the AMA: two years (incumbents John C. Quertermous, M.D., Murray; Carl C. Cooper, Jr., M.D., Bedford)

Trustees for six districts will be elected this year. Of the six incumbents, Dexter Meyer, M.D., and Hubert C. Jones, M.D., have served only one full three-year term and are eligible for re-election; Donald Chatham, M.D., is serving an unexpired term ending in 1964 and is also eligible to succeed himself.

Fifth District (incumbent Carlisle Morse, M.D., Louisville)
Sixth District (incumbent John P. Glenn, M.D., Russellville)
Seventh District: one-year unexpired term (incumbent Donald Chatham, M.D., Shelbyville
Eighth District (incumbent Dexter Meyer, M.D., Covington)
Eleventh District (incumbent Hubert C. Jones, M.D., Berea)
Fifteenth District (incumbent Keith P. Smith, M.D., Corbin)

While At

The Annual Meeting . . . . . .

Keep in Touch By Telephone With Home or Office

While you are attending the annual meeting, your home or office may easily locate you by telephoning the Phoenix Hotel, 255-3210, and asking for the temporary KSMA Headquarters Office.

Make Hotel Reservations Now For Annual Meeting

For those who have made hotel arrangements for the Annual Meeting of KSMA in September, President David M. Cox, M.D., Louisville, urges that this be done as soon as possible.

Among hotels and motels in which rooms are available are: The Phoenix Hotel, The Kentuckian Hotel, Downtowner Motel, Campbell House, Imperial House, Holiday Inn, and The Springs Motel.

Diabetes Association To Meet In Lexington September 23

The second annual meeting of the Kentucky Diabetes Association will be held from 10 a.m. to 4 p.m. on Monday, September 23, at the Imperial Motel, South Broadway and Waller, Lexington, according to information recently released by Franklin B. Moosnick, M.D., Lexington, president of the KDA.

The main guest speaker at the meeting will be Harvey C. Knowles, Jr., M.D., professor of medicine at the University of Cincinnati. Doctor Knowles is well known for his clinical and experimental work in Diabetes Mellitus. The topic of his address will be "The Vascular Complications of Diabetes: Relation to Diabetic Control." Other speakers will discuss varied aspects of diabetes.

Lunch will be served. All physicians are invited to attend. Members of lay affiliates of the KDA and other interested persons are invited to attend the luncheon and afternoon panel discussions. There will be no fee except for those planning to attend the luncheon.

The complete program for the KDA annual meeting will be published in the September issue of The Journal.

Cancer Committee Will Meet

The State Cancer Coordinating Committee, composed of representatives from the Kentucky State Medical Association, the State Department of Health, the Kentucky Cancer Society, and the Kentucky Chapter of the American College of Surgeons, will hold a dinner meeting at 6:30 p.m., on Monday, September 23 in the Phoenix Hotel in Lexington. James C. Drye, M.D., chairman, has urged all members of the committee to be present.

Political Seminar, Banquet Set for Annual Meeting

A political seminar, a cocktail party, and a banquet followed by addresses by the two Kentucky gubernatorial candidates, will be given by KEMPAC (Kentucky Educational Medical Political Action Committee) on Thursday, September 26 at the close of the Annual Meeting, according to Hoyt D. Gardner, M.D., Louisville, chairman of the program.

The seminar, designed to inform physicians in methods of good political action, will be held from 3:30 to 6:30 in the Gold Room of the Lafayette Hotel. The program will be presented by precinct, county and state chairmen of both the Republican and Democratic Parties.

Following the seminar, a cocktail party will be held at 6:30 in the Georgian Room of the Lafayette. At 7:30 the same evening, a banquet for all KSMA members will be held in the Gold Room, featuring addresses by Edward T. (Ned) Breathitt, Democrat, and Louie B. Nunn, Republican, both candidates for the office of Governor of Kentucky.

Tickets for the banquet may be obtained from the KEMPAC booth on the mezzanine floor of the Phoenix Hotel at any time during the Annual Meeting.

1963 Annual Meeting Program Summary

The Kentucky State Medical Association

September 22, 23, 24, 25, and 26

Lexington

SUNDAY, SEPTEMBER 22

9:00 a.m.	Meeting of Board of Directors of Kentucky Physicians Mutual	Place to be Announced
12:30 p.m.	Luncheon Meeting, Board of Trustees	Henry Clay Room, Phoenix Hotel

MONDAY, SEPTEMBER 23

9:00 a.m.	First Meeting of House of Delegates	Crystal Ballroom, Phoenix Hotel
12:00 noon	Luncheon of Reference Committee Chairmen	Henry Clay Room, Phoenix Hotel
2:00 p.m.	Reference Committee Meetings	Third Floor, Phoenix Hotel

TUESDAY, SEPTEMBER 24

8:00 a.m.	Registration	Convention Hall, Phoenix Hotel
8:45 a.m.	Opening Ceremonies	Crystal Ballroom, Phoenix Hotel
9:00 a.m.	First Scientific Session	Crystal Ballroom, Phoenix Hotel
2:00 p.m.	Second Scientific Session	
9:00 a.m.	Specialty Group Sessions (Three Specialty Groups will meet simultaneously at this time. Any KSMA member may attend any of these meetings. See pages 688 & 689 in the program.)	
2:00 p.m.	Specialty Group Sessions (Two meetings will be held at this time. Any KSMA member may attend either of these meetings. (See pages 689 & 690 in program.)	
5:00 p.m.	U. of L. Medical Alumni Cocktail Party	Georgian Room, Lafayette Hotel
7:00 p.m.	U. of L. Alumni Reunion Banquet	Gold Room, Lafayette Hotel

WEDNESDAY, SEPTEMBER 25

9:00 a.m.	Third Scientific Session	Crystal Ballroom, Phoenix Hotel
11:50 a.m.	President's Luncheon	Gold Room, Lafayette Hotel
2:00 p.m.	Specialty Group Sessions (Six Specialty Groups will meet simultaneously at this time. Any KSMA member may attend any of these meetings. See pages 690 & 691 in the program.)	
5:00 p.m.	Dinner Meeting, Board of Trustees	To be announced.
6:00 p.m.	Subscription Dinner and Meeting, House of Delegates	Crystal Ballroom, Phoenix Hotel

THURSDAY, SEPTEMBER 26

9:00 a.m.	Fourth Scientific Session	Crystal Ballroom, Phoenix Hotel
12:00 noon	Board of Trustees Meeting and Luncheon	To be announced.
2:00 p.m. - 3:30 p.m.	Fifth Scientific Session	Crystal Ballroom, Phoenix Hotel
2:00 p.m.	Specialty Group Sessions (Four Specialty Groups will meet simultaneously at this time. Any KSMA member may attend any of these meetings. See page 692 in the program.)	
3:30 p.m.	KEMPAC Political Seminar	Gold Room, Lafayette Hotel
7:30 p.m.	KEMPAC Banquet	Gold Room, Lafayette Hotel

A 30-minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting the Scientific and Technical Exhibits.

(Full Scientific Program starts on page 688)

SCIENTIFIC PROGRAM

J. W. Holland Memorial Meeting

The Kentucky State Medical Association

Phoenix Hotel, Lexington

TUESDAY, SEPTEMBER 24

MORNING SESSION

General Session

8:45 **Opening Ceremonies**
Welcome—M. Randolph Gilliam, M.D., Lexington
Invocation—
David M. Cox, M.D., Louisville, KSMA President, Presiding

9:00 **TV Clinic—"Diagnosis and Treatment of Common Skin Disorders"**
Ullin W. Leavell, Jr., M.D., Lexington, Moderator
A. B. Loveman, M.D., Louisville
Harold O. Perry, M.D., Rochester, Minnesota
Carey C. Barrett, M.D., Lexington
William E. McDaniel, M.D., Lexington

10:00 **Visit Exhibits**

10:30 **Panel Discussion—"Dermatologic Problems of General Medicine"**
A. B. Loveman, M.D., Louisville, Moderator
Dermatologic Aspects — Harold O. Perry, M.D., Rochester, Minnesota
Pediatric Aspects—Walter T. Hughes, M.D., Louisville
Internist's Aspects—Lloyd D. Mayer, M.D., Lexington
General Practitioner's Aspects — Arnold C. Williams, M.D., Lexington
"What's New and What's True of What's New in Dermatology" — Winston U. Rutledge, M.D., Louisville

11:00 Question and Answer Period on any Dermatological Problems. Questions Must be Submitted in Writing.
Lunch — 12:00 Noon

Specialty Group Meetings

Kentucky Obstetrical & Gynecologic Society Fountain Room — Phoenix Hotel

9:00 **"Menstrual Disorders of the Teenager"**
John W. Greene, Jr., M.D., Lexington

9:30 **"Cesarean Hysterectomy"**
Douglas M. Haynes, M.D., Louisville

10:00 **Visit Exhibits**

10:30 **"Studies and Management of Ectopic Pregnancy"**
H. Hudnall Ware, Jr., M.D., Richmond, Virginia

11:00 **"Choice of Treatment in Carcinoma of the Endometrium"**

GUEST SPEAKERS

HAROLD O. PERRY, M.D.
Rochester, Minn.

Assistant professor in Dermatology, Mayo Foundation, Graduate School, University of Minnesota; member staff in section of Dermatology and Syphilology, Mayo Clinic; graduated University of Minnesota Medical School, 1946; interned U. S. Naval Hospital, Oakland, Cal.; member American Academy of Dermatology and Syphilology; American Dermatological Association, and the Society of Investigative Dermatology; Author of more than 50 articles on dermatological subects; certified by the American Board of Dermatology and Syphilology, 1953.

H. HUDNALL WARE, JR., M.D.
Richmond, Va.

Professor and chairman, Department of Obstetrics and Gynecology, Medical College of Virginia; graduated Medical College of Virginia, 1924; fellow and past vice president, American Gynecological Society; fellow and vice president, American Association of Obstetricians and Gynecologists; fellow and past president, South Atlantic Association of Obstetricians and Gynecologists; fellow, American College of Surgeons, American College of Obstetricians and Gynecologists; past president and fellow Southern Obstetrical and Gynecological Society; associate examiner, American Board of Obstetrics and Gynecology.

H. H. YOUNG, M.D.
Rochester Minn.

Clinical professor of Orthopedic Surgery, Mayo Foundation, Graduate School of Medicine, University of Minnesota; consulting orthopedic surgeon, Mayo Clinic; chairman of the sections of orthopedic surgery, Mayo Clinic; received M.D. from Rush Medical College, Chicago, 1934; M.S. in Orthopedic Surgery from University of Minnesota, 1940; interned at Chicago Municipal Contagious Hospital and Presbyterian Hospital, Chicago; member, American Academy of Orthopedic Surgeons, American College of Surgeons, and American Rheumatism Association; certified by the American Board of Orthopedic Surgery.

Kentucky Orthopaedic Society
Henry Clay Room — Phoenix Hotel

9:00 **"The Management of Osteomyelitis of the Thoracic Spine"**
E. Q. Parr, M.D., Lexington

9:20 **"Synovioma vs. Giant Cell Tumor"**
B. Bloss, M.D., Evansville, Indiana

9:40 **"Chondromalacia of the Patella"**
D. G. Costigan, M.D., Louisville

10:00 **Visit Exhibits**

10:30 **"Athletic Injuries of the Knee"**
George M. Gumbert, Jr., M.D., Lexington

10:50 **"Supracondylar Fractures of the Femur—Review of Sixty Cases"**
Enrique Martinez, M.D., Lexington
David B. Stevens, M.D., Lexintgon

11:10 **"A Knee Prosthesis: Review of Cases"**
H. H. Young, M.D., Rochester, Minnesota

11:30 **Movie: "Knee Prostheses"**
H. H. Young, M.D., Rochester, Minnesota

Kentucky Urological Society
Rooms 361 and 362 — Phoenix Hotel

9:00 **"Urodynamics"**
David M. Davis, M.D., Haverford, Pennsylvania

10:00 **Visit Exhibits**

10:30 **Pyelogram Hour Presented by the Kentucky Urologists Who Will Bring Individual Cases of Interest to All**

AFTERNOON SESSION

General Session

Alfred O. Miller, M.D., Louisville, Vice President, Central, presiding

2:00 **Panel Discussion—"Etiologic and Therapeutic Aspects in Pyelonephritis"**
Robert Lich, Jr., M.D., Louisville, Moderator
Internist's Aspects — Robert I. Wise, M.D., Philadelphia, Pennsylvania
Obstetrical Aspects—H. Hudnall Ware, Jr., M.D., Richmond, Virginia
Pediatric Aspects — Katharine Dodd, M.D., Atlanta, Georgia
Urologic Aspects — David M. Davis, M.D., Haverford, Pennsylvania

3:30 **Visit Exhibits**

4:00 **"Plea for Conservatism in the Treatment of Fractures"**
H. H. Young, M.D., Rochester, Minnesota

4:20 **"Our Common Goal"**
Charles D. Carter, D.M.D., Bowling Green

Specialty Group Meetings

Kentucky Psychiatric Association
Fountain Room — Phoenix Hotel

2:00 **Panel Discussion—"The Role and Contributions of Medicine to Community Mental Health"**
Joseph B. Parker, Jr., M.D., Lexington, Moderator
"The Role and Contributions of the Psychiatrist in Private Practice" (10 minutes)
Hollis Johnson, M.D., Louisville
"The Role and Contribution of the Non-Psychiatric Physician" (10 minutes)
Harold J. Schupbach, M.D., Owensboro
"The Contributions of Psychiatrists and Medical Centers to School Mental Health" (10 minutes)
Torkel Scholander, M.D., Uppsala, Sweden
The Role and Contributions of a State Department of Mental Health (10 minutes)
Dale H. Farabee, M.D., Lexington

DAVID M. DAVIS, M.D.
Haverford, Pa.

Visiting lecturer in Urology, Graduate School of Medicine, University of Pennsylvania; former professor of urology, Jefferson Medical College, received emeritus status in 1951; graduated Johns Hopkins University School of Medicine, 1911; past president, Mid-Atlantic Section, American Urological Association, Philadelphia Urological Association, American Association of Genito-Urinary Surgeons; vice president, International Urologic Society; former treasurer, College of Physicians of Philadelphia; author of 128 books and journal articles, including **Mechanisms of Urologic Disease** (1953), and **Young's Practcie of Urology** (co-author 1926).

ROBERT I. WISE, M.D.
Philadelphia, M.D.

Magee professor of medicine and head of department, Jefferson Medical College, Philadelphia; graduated University of Texas Medical Branch, 1950; interned U.S.P.H.S. Hospital, New Orleans; residency internal medicine, University of Minnesota Hospitals; attending physician-in-chief, Jefferson Medical College Hospital; diplomate American Board of Internal Medicine; fellow, American College of Physicians; member medical advisory board, **The Medical Letter** and editorial board, **Annals of Internal Medicine**; member American Federation for Clinical Research.

KATHARINE DODD, M.D.
Atlanta, Ga.

Graduated Johns Hopkins Medical School in 1921; former Distinguished Professor of Pediatrics, University of Louisville School of Medicine; retired from U of L in 1960 and now associated with Emory University; a native of Providence, R. I.; former professor and head of Department of Pediatrics, University of Arkansas School of Medicine; addressed KSMA Annual Meeting, 1956; named "Woman Physician of Year" by Ky. M.D.'s, 1958; received Elizabeth Blackwell Award, 1959; former associate professor pediatrics and research fellow, Children's Hospital Research Foundation, Cincinnati.

3:00 **Visit Exhibits**
3:30 **"The Education and Training of Physicians and Psychiatrists for Community Psychiatry** (30 minutes)
Bernard Holland, M.D., Atlanta, Georgia
Discussion—(from the floor)
4:15 Business Meeting

WEDNESDAY, SEPTEMBER 25

MORNING SESSION

General Session

Hugh Mahaffey, M.D., Richmond, Vice president, (Eastern) presiding

9:00 **Color TV Clinic—"Obesity"**
William W. Winternitz, M.D., Lexington, Moderator
Case Presentations:
Patient interview by—Beverley T. Mead, M.D., Lexington; Robert W. Chamberlin, Jr., M.D., Lexington
Problem as seen by General Practitioner—William VonderHaar, M.D., Louisville
Psychiatric Aspects—Bernard Holland, M.D., Atlanta, Georgia
Pediatric Aspects — Kenneth P. Crawford, M.D., Louisville
Genetic Aspects—C. Charlton Mabry, M.D., Lexington
10:30 **Visit Exhibits**
11:00 **Presentation of Awards**
President's Address

PRESIDENT'S LUNCHEON

Gold Room, Lafayette Hotel

11:50 a.m.

David M. Cox, M.D., Louisville, presiding

Invocation
Irvin Lunger, Ph.D., President, Transylvania University, Lexington

Recognition
David M. Cox, M.D.

Awards Presentation
William H. Bizot, M.D., Louisville, KSMA Awards Committee Chairman

"How to Keep From Going Nuts in a Nutty World"
Henry M. Johnson, Ph.D., D.D., Minister of Education, First Methodist Church, Fort Worth, Texas.

AFTERNOON SESSION

(No General Session)

Specialty Group Meetings

All KSMA members are urged to attend any of these specialty group sessions.

Kentucky Society of Anesthesiologists
Rooms 461 and 462 — Phoenix Hotel

2:00 **Business Meeting**
3:00 **Visit Exhibits**
3:30 **"Perspective in Anesthesiology"**
Jay J. Jacoby, M.D., Milwaukee, Wisconsin

Kentucky Academy of General Practice
Crystal Ballroom — Phoenix Hotel

2:00 **"Surgery of the Face and Neck on Out-patients"**
Andrew M. Moore, M.D., Lexington
2:30 **"Oral, Ocular and Skin Findings in Some Cutuneous and Systemic Diseases"**
Harold O. Perry, M.D., Rochester, Minnesota
3:00 **Visit Exhibits**
3:30 **Color TV—"Problems in Pediatric Neurology"**
Joseph Keith, Jr., M.D., Lexington

CHARLES D. CARTER, D.M.D.

Bowling Green

A native of Kentucky; received D.M.D. degree from University of Louisville School of Dentistry; interned U.S.P.H.S. Hospital, New Orleans; engaged in private practice; chairman, first statewide Conference on Dental Health Education; fellow, American College of Dentists; former delegate and executive board member of KDA; former component society secretary; chairman, KDA Council on Dental Health; member, Advisory Council for Medical Assistance; member, Dental Advisory Council to the State Health Department's Dental Division.

BERNARD HOLLAND, M.D.

Atlanta, Ga.

Professor and chairman, Department of Psychiatry, Emory University; graduated from Emory with M.D. degree in 1943; interned Grady Memorial Hospital; certified American Board of Internal Medicine and American Board of Psychiatry and Neurology; member American Psychiatric Association and American Psychopathological Association; president, Metropolitan Atlanta Council on Alcoholism; serves on medical education committee of American Psychiatric Association and the test committee of National Board of Medical Examiners; member Georgia Association for Mental Health.

JAY J. JACOBY, M.D.

Milwaukee, Wis.

Professor and chairman, Department of Anesthesio, Marquette University School of Medicine; received M.D. degree University of Minnesota, 1941; interned Kings County Hospital, Brooklyn; received PhD degree, University of Chicago, 1947; former professor and director Department of Anesthesia at Ohio State University, 1950-59; diplomate, American Board of Anesthesiology, 1948; fellow, International College of Anesthesiologists and the American College of Anesthesiologists; native of New York City; member, Association of University Professors.

Kentucky Chapter, American Academy of Pediatrics
Georgian Room — Lafayette Hotel

2:00 **"Diabetes"**
Katharine Dodd, M.D., Atlanta, Georgia

3:00 **"Septicemia in Newborn and Young Infants"**
Katharine Dodd, M.D., Atlanta, Georgia

4:00 **Visit Exhibits**

Kentucky Chapter, American College of Physicians
Henry Clay Room — Phoenix Hotel

2:00 **"Fat Embolism"**
Bernard I. Popham, M.D., Louisville

2:30 **"A Rational Approach to the Selection of Antibiotics in Bacterial Diseases"**
Robert I. Wise, M.D., Philadelphia, Pennsylvania

3:00 **"Use of Arterial Blood Gas Measurements in Patient Care"**
Jerome E. Cohn, M.D., Lexington

3:30 **"Paroxysmal Ventricular Fibrillation"**
William R. Gray, M.D., Louisville

4:00 **Visit Exhibits**

Kentucky Radiological Society
Rooms 361 and 362 — Phoenix Hotel

2:00 **"Large Rugal Folds in the Stomach"**
John R. Hodgson, M.D., Rochester, Minnesota

3:00 **Visit Exhibits**

3:30 **"Unusual Biliary Tract Disease"**
John R. Hodgson, M.D., Rochester, Minnesota

Kentucky Chapter, American College of Surgeons
Fountain Room — Phoenix Hotel

2:00 **"Problems in the Management of Hemangiomas and Vascular Tumors"**
Benjamin F. Rush, Jr., M.D., Lexington

2:30 **"Septic Shock"**
Allan Lansing, M.D., Louisville

3:00 **Visit Exhibits**

3:30 **"Surgical Management of Inflammatory Diseases of the Pancreas"**
Rene Menguy, M.D., Lexington

4:00 **"Management of Breast Carcinoma"**
Richard D. Brasfield, M.D., New York City

THURSDAY, SEPTEMBER 26

MORNING SESSION

General Session

Joseph R. Miller, M.D., Benton, Vice president (Western) presiding

9:00 **Color TV Panel Discussion—"Tumors of the Head and Neck"**
Benjamin F. Rush, Jr., M.D., Moderator
EEN&T Aspects—Jack R. Anderson, New Orleans, Louisiana
Surgical Aspects—Richard D. Brasfield, M.D., New York City
X-Ray Therapy Aspects—Robert H. Greenlaw, M.D., Lexington
Internist's View—Giovanni Raccuglia, M.D., Louisville

10:30 **Visit Exhibits**

JOHN R. HODGSON, M.D.

Rochester, Minn.

Consultant in diagnostic roentgenology, Mayo Clinic; associate professor of radiology, Mayo Foundation; graduated University of Michigan Medical School, 1940; internship and residency, Providence Hospital, Detroit; M. S. in radiology, University of Minnesota; diplomate, American Board of Radiology; fellow, American College of Radiology; member, American Gastroenterological Association; first vice president, Radiological Society of North America; member, American Roentgen Ray Society.

RICHARD D. BRASFIELD, M.D.

New York, N.Y.

Clinical instructor in surgery, Cornell University Medical College; assistant clinician, Sloan Kettering Institute; Memorial Hospital, associate staff president; graduated Vanderbilt University Medical School with M.D. degree 1944; interned Vanderbilt University Hospital; diplomate, American Board of Surgery; member, American College of Surgeons and American Geriatric Society; member, American Association of Medical Writers and American Association for Advancement of Science; received the General John J. Pershing Medal, 1940.

CHARLES A. PERERA, M.D.

New York, N. Y.

Attending ophthalmologist, Presbyterian Hospital and Vanderbilt Clinic; member, Board of Surgeons, Institute of Ophthalmology, Columbia - Presbyterian Medical Center; associate clinical professor of Ophtalmology, Columbia University; graduated Columbia University with M.D., 1930, and Med.Sc.D., 1936; diplomate, National Board of Medical Examiners and American Board of Ophthalmology; editor, *May's Manual of Diseases of the Eye*; chairman, Medical Advisory Committee of National Council to Combat Blindness; member, American Ophthalmological Society; consulting ophthalmologist, Vassar Bros. Hospital, Poughkeepsie.

11:00 **Panel Discussion—"Environmental Factors in Lung Cancer"**
Hugh S. Fulmer, M.D., Lexington, Moderator
Chest Physicians' View—Paul W. Sanger, M.D., Charlotte, North Carolina
Public Health View—Christian R. Klimt, M.D., Baltimore, Maryland
Pathological Aspects—Averill A. Liebow, M.D., New Haven, Connecticut
Statisticians' Aspect—Alan Ross, Lexington
Lunch — 12:00 Noon

THURSDAY, SEPTEMBER 26

Specialty Group Meetings

Kentucky EEN&T Society
Henry Clay Room — Phoenix Hotel

10:00 **"Mass Glaucoma Screening in Kentucky"**
James L. Stambaugh, Jr., M.D., Lexington
10:30 **"Practical Experience in the Office Use of Ophthalmodynamometry"**
Edward C. Shrader, Jr., M.D., Louisville
11:00 **Business Meeting**

AFTERNOON SESSION

General Session

George P. Archer, M.D., Prestonsburg, President-elect, presiding

2:00 **Panel Discussion—"Hypertension"**
Thornton Scott, M.D., Lexington, Moderator
General Practitioner's Aspects—Robert M. Sirkle, M.D., Lexington
Surgical Aspects—Frank C. Spencer, M.D., Lexington
Radiological Aspects—John R. Hodgson, M.D., Rochester, Minnesota
Internist's Aspects—Ralph M. Denham, M.D., Louisville
Anesthesiological Aspects—Jay J. Jacoby, M.D., Milwaukee, Wis.
3:30 **End of the Scientific Program**

Specialty Group Meetings

Kentucky EEN&T Society
Henry Clay Room — Phoenix Hotel

2:00 **"Technical Surgical Problems in Strabismus"**
Charles A. Perera, M.D., New York City
2:30 **"Allergic Problems in ENT Practice"**
Jack R. Anderson, M.D., New Orleans, Louisiana
3:00 **Visit Exhibits**
3:30 **"Stapedioplasty: Autogenous or Prosthetic"**
Arthur Juers, M.D., Louisville
4:00 **"Experience with Cyclectomy for Local Excision of Ciliary Body Lesions"**
C. Dwight Townes, M.D., Louisville, and
Harry A. Pfingst, M.D., Louisville

Kentucky Society of Pathologists
Rooms 461 and 462 — Phoenix Hotel

2:00 **"Benign Metastasizing Leiomyoma of the Uterus"**
James E. Parker, M.D., Louisville
2:20 **"Sudden and Unexpected Deaths in Infancy; Pathologic Anatomy; Pathogenesis and Prevention"**
Daniel Stowens, M.D., Louisville
2:40 **"Focal Encephalitis of the Temporal Lobe"**
Ryland P. Byrd, M.D., Louisville

3:00 **Visit Exhibits**
3:30 **"Recent Discoveries in Pulmonary Disease"**
Averill A. Liebow, M.D., New Haven, Connecticut
3:50 **"The Colonic Polyp—Surgical Pathology Dilemma"**
Edward J. Fadell, M.D., Louisville
Marvin A. Lucas, M.D., Louisville

Kentucky Association of Public Health Physicians
Rooms 361 and 362 — Phoenix Hotel

2:00 **"The Epidemiology of Diabetes"**
Christian R. Klimt, M.D., Baltimore, Maryland
2:30 **Discussion of the above presentation**
3:00 **Visit Exhibits**
3:30 **"Relationship Between the Private Practitioner and the Public Health Physician"**
Robert H. English, M.D., Henderson
4:00 **Discussion of the above presentation**
4:30 **Business Meeting**

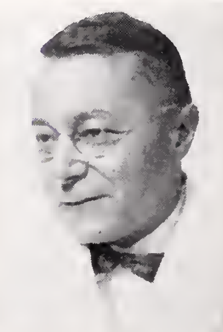
PAUL W. SANGER, M.D.
Charlotte, N.C.

Chief, thoracic and cardiovascular surgery, Charlotte Memorial Hospital; member, Board of Directors, United Medical Research Foundation of North Carolina; graduated, Vanderbilt University Medical School, 1931; resident in surgery, Duke University Hospital; native of Oklahoma; diplomate, American Board of Surgery and Board of Thoracic Surgery; surgical consultant, Surgeon General U.S. Army—tour of Far East, 1948—Korea, 1953, director, North Carolina Heineman Foundation; chairman Heineman and Hartford Foundation laboratories.

CHRISTIAN R. KLIMT, M.D.
Baltimore, Md.

Associate professor and director, Division of Epidemiology and Biostatistics, University of Maryland, School of Medicine; graduated, University of Vienna, Austria, 1944; graduated Johns Hopkins School of Hygiene and Public Health with Dr. P.H. degree, 1959; formerly associated with the World Health Organization and the Rockefeller Institute; former associate professor of epidemiology, University of Minnesota, College of Medical Sciences; member Royal Society of Tropical Medicine and Hygiene; author of numerous publications and reports; member Association of Teachers of Preventive Medicine.

AVERILL A. LIEBOW, M.D.
New Haven, Conn.



John Slade Ely Professor of Pathology, Yale University School of Medicine, 1935; former president International Academy of Pathology, 1953-4; chairman, National Research Council Committee on Pathology; consultant to Armed Forces Institute of Pathology member, editorial boards of Laboratory Investigation, Circulation Research and Annual Review of Medicine; member, Advisory Committee on Atomic Bomb Casualty Commission; consultant to World Health Organization Committee on Cancer; Guggenheim Fellow, 1957-8; native of Austria.

Scientific Exhibits To Emphasize Medical Progress

Sixteen scientific exhibits on varied subjects will demonstrate medical progress and the latest in medical research during the 1963 KSMA Annual Meeting, according to Benjamin B. Jackson, M.D., Louisville chairman of the KSMA Committee on Scientific Exhibits.

One hundred and thirty-five feet of space in the Stephen Foster and Breckinridge Rooms on the Mezzanine Floor of the Phoenix have been set aside for the exhibits.

A plaque will be awarded this year for the second time to the exhibit judged to be the best. In addition, each scientific exhibitor participating at the 1963 meeting will be awarded a certificate.

Scientific Exhibitors

1. **Direct Percutaneous Non-Catheter Brachial Angiography (Left Pan-Arteriography — Right Cerebral Angiography)**
   T. R. Marshall, M.D., J. T. Ling, M.D., R. Gonzalez, M.D., & A. Hatam, M.D.
   University of Louisville School of Medicine

2. **Radiation therapy in the treatment of Cancer of the Tongue**
   Ralph M. Scott, M.D., & Herbert E. Brizel, M.D.
   University of Louisville School of Medicine

3. **Kentucky Society for the Prevention of Blindness**
   James L. Stambaugh, Jr., M.D.

4. **How to find it? How to get it?**
   Kornhauser Memorial Medical Library, University of Louisville School of Medicine

5. **Automotive Crash Injury Research**
   Cornell Aeronautical Laboratory, Inc. of Cornell University

6. **'Benign' Breast Lumps**
   David W. Kinnaird, M.D.

7. **Examination of the Stomach and Duodenal Bulb with the Fiberscope**
   F. Norman Vickers, M.D., Thomas R. Marshall, M.D. and Samuel H. Cheng
   University of Louisville—Departments of Medicine & Radiology

8. **Management of Arterial Embolism**
   Raymond J. Krause, M.D., John J. Cranley, M.D., Edward S. Strasser, M.D., Charles D. Hafner, M.D. & Moheb A. S. Hallaba, M.B.Ch.B.
   The Good Samaritan Hospital, Cincinnati

9. **Diagnosis and Treatment of Brain Lesions**
   J. C. Malek, M.D., Peter H. Jones, M.D., Leslie W. Blakey, M.D. & James T. McClellan, M.D.
   Lexington Clinic

10. **Three Year Follow-up of Peptic Ulcer Patients**
    Fred J. Phillips, M.D., David Shoemaker, M.D., & C. L. Chai, M.D.
    Quakertown, Pa.

11. **Central Tympanic Perforation Closure—Office and Surgical**
    Arthur L. Juers, M.D.

12. **Drug Allergy**
    Maurice Kaufmann, M.D. & Martin P. Kaplan, M.D.

13. **Operative Cholangiography**
    Charles H. Moore, M.D. & Khamis Saba, M.D.
    Cooperating with the Good Samaritan Hospital, Cincinnati

14. **Applications of Extracorporeal Surgery**
    Porter Mayo, M.D., Graydon Long, M.D. & Richard McElvein, M.D.

15. **American Medical Association — Education and Re-research Foundation**
    KSMA AMA-ERF Committee Walter I. Hume, Jr., M.D., Chairman

16. **Congenital Malformations of the Kidney**
    Daniel Stowens, M.D.
    University of Louisville School of Medicine & Children's Hospital

17. **To Be Announced**
    State Department of Health

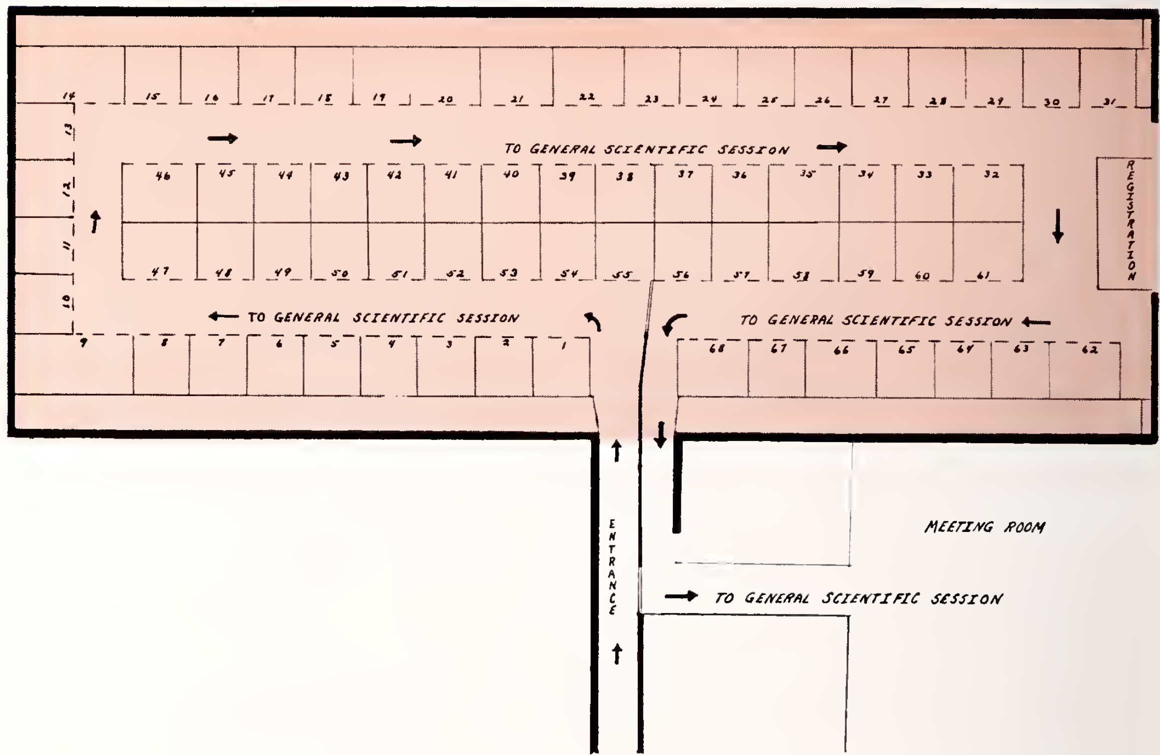
Technical Exhibits Will Be Outstanding and Varied

An assortment of note-worthy items and ideas will be provided to Kentucky physicians by the technical exhibits scheduled for the 1963 KSMA Annual Meeting, according to recently completed plans.

A 30-minute intermission is scheduled for each morning and afternoon Scientific Session and during the Specialty Group meetings in order to provide time for every physician to visit both Scientific and Technical Exhibits.

All members are urged to take this opportunity to visit all or as many as possible of these interesting presentations so that they may study the progress being made in the many areas of the profession.

Technical Exhibits



Abbott Laboratories (61)
Ames Company Inc. (63)
Arnar-Stone Laboratories (36)
Ayerst Laboratories (30)
Baker Laboratories Inc. (33)
Blue-Cross-Blue Shield (25)
Borcherdt Company (39)
Burroughs Wellcome & Company (10)
Burton, Parsons & Company (3)
Cameron-Miller Surgical Instruments Co. (6)
Ciba Pharmaceutical Company (67)
Coca-Cola Company (14)
Dictaphone Corporation (7)
Dome Chemicals, Inc. (41)
Eaton Laboratories (15)
Encyclopedia Americana (44)
Encyclopedia Britannica (50)
Geigy Pharmaceuticals (48)
Gerber Products Company (45)
Guild of Prescription Opticians of Kentucky (40)
John Hancock Mutual Life Insurance Co. (12)
Irving Air Chute Company, Inc. (5)
Johnson & Johnson (64)
Kay Surgical, Inc. (20)
Lederle Laboratories (55)
Eli Lilly and Company (32)
J. B. Lippincott Company (2)
Lloyd Brothers, Inc. (37)
Logan Company (22)
McNeil Laboratories, Inc. (59)
J. A. Majors Company (31)
Malkin Instrument Company, Inc., (35)
Mead Johnson Laboratories (62)
Medco Products Company (42)
Medical Protective Co., The (11)
Merck, Sharp & Dohme (58)
Organon, Inc. (19)
Ortho Pharmaceutical Corporation (65)
Parke-Davis & Company (1)
Pfizer Laboratories (56)
William P. Poythress & Co., Inc., (18)
R. J. Reynolds Tobacco Co. (28)
A. H. Robins Co., Inc. (27)
Roche Laboratories (68)
J. B. Roerig & Company (51)
William H. Rorer, Inc. (34)
Ross Laboratories (13)
Sandoz Pharmaceuticals (8)
Schering Corporation (54)
Julius Schmid, Inc. (16)
Clayton L. Scroggins Associates (9)
G. D. Searle & Company (46)
Smith Kline & French Laboratories (66)
Smith, Miller & Patch, Inc. (57)
Snell's Limb & Brace Company (24)
E. R. Squibb & Sons (53)
Stuart Company (26)
Therma-Fax Sales, Inc. (49)
United States Tobacco Co. (4)
Upjohn Company (60)
U. S. Vitamin & Pharmaceutical Corporation (29)
Wallace Laboratories (23)
Warner-Chilcott Laboratories (21)
Warren-Teed Products Company (17)
Westwood Pharmaceuticals (43)
Winthrop Laboratories (47)
Max Wocher & Son Company (52)
Zimmer Manufacturing Co. (38)

1963 KSMA Golf Tourney Set For Lexington Country Club

Lexington Country Club, located on the Paris Road, Highways 27 & 68, has been chosen as the site of the 1963 Annual KSMA Golf Tournament on September 23—26. This beautiful club will prove to be a pleasant challenge to all members of the KSMA Golf Association.

Kenton D. Leatherman, M.D., Louisville, Chairman of the KSMA Golf Committee, requests that all participants in the tourney play their rounds on Monday, September 23, if possible.

Participants need not submit handicaps this year, as the Bankers Handicap System will be used which gives a high handicap golfer the same opportunity of being a winner as the low handicap golfer.

This year for the first time, four permanent trophies will be awarded, instead of the traveling trophies used in the past. Recipients of the trophies will be low-net, low-gross (Bankers System), low-net senior division, and low-gross senior division providing more than five senior participants are entered in the tourney. A number of additional prizes will be purchased at the Lexington Country Club Pro-Shop for others scoring well in the tournament.

Winners last year included: Darl B. Shipp, M.D., Dry Ridge, Championship Cup for low-net; C. J. Scalzitti, M.D., Louisille, Low-Gross Cup; T. J. Overstreet, M.D., Lexington, Senior Championship Cup.

Co-Chairman of the KSMA Golf Committee is Marion G. Brown, M.D., Lexington. Other committee members serving under Doctor Leatherman and Doctor Brown are: James Archer, M.D., Paintsville; Harold W. Baker, M.D., Louisville; Clifton G. Follis, M.D., Glasgow; Edward G. Houchin, M.D., LaGrange; Martin Kaplan, M.D., Louisville; Harvey B. Stone, M.D., Hopkinsville; and William C. Wolfe, M.D., Louisville.

If you wish to play in the KSMGA 1963 Tourney, please clip the application blank below and enclose $7.00 which includes both dues in KSMGA and Green Fees.

Clip Here

APPLICATION FOR MEMBERSHIP
KSMA Golf Association

(Please complete and return immediately)

to: KSMA Golf Committee
Kentucky State Medical Association
3532 Janet Avenue
Louisville 5, Kentucky

Name ....

Street ....

Town ....

Cash enclosed is $7.00 .... **Check, $7.00** ....

.... **I will play on Monday, September 23.**

.... **Sorry I cannot play on Monday. I will play on September 24—25— or 26 (circle which day).**

PROGRAM

FORTY-FIRST ANNUAL CONVENTION

OF THE

WOMAN'S AUXILIARY

TO THE

KENTUCKY STATE MEDICAL ASSOCIATION

SEPTEMBER 24 - 25 - 26

1963

LAFAYETTE HOTEL **LEXINGTON, KENTUCKY**

REGISTRATION:

Mezzanine, Lafayette Hotel
Monday 12 noon—5 p.m.
Tuesday 8 a.m.—5 p.m.
Wednesday 9 a.m.—11 a.m.

MONDAY, SEPTEMBER 23

4:00 P.M.

Program Prevue, Red Room; (County Presidents and Program Chairmen)

TUESDAY, SEPTEMBER 24

8:00 A.M.

Pre-convention Board Breakfast: Red Room, Lafayette Hotel (subscription). All state officers, councilors, state committee chairmen, county auxiliary presidents and the three immediate past presidents are urged to attend.

10:00 A.M.

GOLD ROOM

Formal opening of the 41st Annual Convention of the Woman's Auxiliary to the Kentucky State Medical Association. Mrs. James Sears Rich, President, presiding.

Invocation .... Mrs. J. Andrew Bowen, Louisville
Corresponding Secretary

Pledge of Allegiance to the Flag .... Mrs. Guy Morford
Owensboro, Immediate Past President

Pledge of Loyalty .... Mrs. Earl Roles, Prospect
National Vice President

Address of Welcome .... Mrs. C. Edward Rankin
Lexington, President,
Fayette County Auxiliary

Presentation of Distinguished Guests
Mrs. James Sears Rich, Lexington

Adoption of Convention Rules ...... Mrs. Carlisle Morse
Louisville, Parliamentarian

Announcements .... Mrs. Thornton Scott
Lexington, Convention Chairman

Roll Call of Delegates ...... Mrs. Robert J. Salisbury
Mt. Sterling, Recording Secretary

Minutes of the 40th Annual Convention
Mrs. Robert J. Salisbury

Report of the Board of Directors
Mrs. Robert J. Salisbury

Report of the 1963 National Convention
Mrs. J. Jack Martin, Tompkinsville
Second Vice-president

Report of the Councilor of the Woman's Auxiliary to the Southern Medical Association
Mrs. William W. Wainer
Providence

Greetings .... Mrs. Elias Margo, President
Woman's Aux. Southern Medical Assn.
Oklahoma City, Oklahoma

President's Address .... Mrs. James Sears Rich
Lexington

Reports of Officers:

President-elect and Membership Chairman
Mrs. J. Murray Kinsman,Louisville

Treasurer .... Mrs. Graydon Long, Lexington

Corresponding Secretary ..... Mrs. J. Andrew Bowen
Louisville

Report of Nominating Committee
Mrs. Guy Morford, Owensboro

Presentation of the 1963-1964 Budget
Mrs. David Cox, Louisville
Finance Chairman

Election of 1963-1964 Nominating Committee

Old Business

New Business

Reports of Chairmen

Report of Registration .... Mrs. C. Edward Rankin
Lexington

In Memoriam .... Mrs. Proctor Eubank
Louisville

Participants:

Mrs. Raymond Jones, Louisville
Mrs. C. Edward Rankin, Lexington
Mrs. Roy Sanders, Dorton
Mrs. Paul Taylor, Providence
Mrs. M. G. Veal, Henderson

LUNCHEON

12:30 P.M.

GOLD ROOM

Honoring

Past Presidents, Members-at-Large, and Distinguished Guests

Invocation .... Mrs. Gaithel Simpson
Greenville

Presentation of Membership Awards
Mrs. J. Murray Kinsman, Louisville
President-Elect

"Medical Political Problems of the Future"
Ever Curtis, M.D.
Gloucester, Massachusetts

2:00 P.M.

GOLD ROOM

Address .... George P. Archer, M.D.
President-elect, KSMA

Reports of County Auxiliary Presidents
Vice-presidents presiding:
Mrs. Paul F. Rizk
Grayson
Mrs. J. Jack Martin
Tompkinsville
Mrs. Ballard Cassady
Pikeville
Mrs. Charles Kissinger
Henderson

Bell, Boyd-Carter-Greenup, Boyle, Calloway Daviess, Fayette, Franklin, Fulton-Hickman, Harlan, Henderson, Hopkins, Jefferson, Laurel, Madison, Marion-Washington, Mason, McCracken, Montgomery, Muhlenberg, Pike, Pulaski, Warren.

Musical Skit ..... Whitley County Auxiliary Members

3:45 P.M.

HISTORIC TOUR OF BLUEGRASS

to

Waveland, John Hunt Morgan House, Henry Clay House
Optional Tour: University of Kentucky Medical Center
Leaving from entrance Lafayette Hotel 3:45 p.m.

WEDNESDAY, SEPTEMBER 25

SWAP BREAKFAST

8:00 - 9:00 A.M.

RED ROOM

For outgoing and incoming Officers, Chairmen, Councilors.

9:15 A.M.

GEORGIAN ROOM

Formal Convention Session

Invocation .... Mrs. George Widener, Paducah

Roll Call .... Mrs. Robert J. Salisbury
Mt. Sterling

Reading of Minutes .... Mrs. Robert J. Salisbury

Presentation of Distinguished Guests

Announcements .... Mrs. Thornton Scott
Convention Chairman

Address .... David M. Cox, M.D.
President, KSMA
Louisville

Presentation of Community Service Award
David M. Cox, M.D.

Address .... Mrs. William H. Evans
President-elect, Woman's
Auxiliary to AMA
Youngstown, Ohio

Election of Officers

Installation of Officers .... Mrs. William H. Evans

Presentation of Gavel and Pin ... Mrs. James Sears Rich
Lexington

Inaugural Address .... Mrs. J. Murray Kinsman
Louisville

Announcement of Committee Chairmen
Mrs. C. Edward Rankin
Lexington

Courtesy Resolutions .... Mrs. George P. Archer
Prestonsburg

LUNCHEON

12:30 P.M.

LEXINGTON COUNTRY CLUB

Honoring

Mrs. William H. Evans, President-elect, Woman's Auxiliary to the American Medical Association

Invocation .... Mrs. Dennis Penn
President-elect, Auxiliary
to the Fayette County
Medical Society
Lexington

Presentation of Distinguished Guests
Presentation of Past Presidents
Presentation of Officers
Adjournment to an afternoon at the Lexington Trotting Track

THURSDAY, SEPTEMBER 26

8:45 A.M.

RED ROOM

Post-Convention Board Breakfast

Presiding .... Mrs. J. Murray Kinsman
President
Louisville

Invocation .... Mrs. Carlisle Morse
Louisville

Meeting of Membership Committee

RULES OF THE CONVENTION

1. Badges must be worn by the voting body during all general sessions.
2. Delegate privileges are transferable only with the knowledge and approval of the Credentials Committee.
3. Officers and Delegates are requested to sit in the assigned seats. All persons appearing on the program are requested to sit near the front.
4. When addressing the Chair, a speaker shall announce her name and the name of her county auxiliary.
5. Each speaker from the floor shall be limited to *two* minutes. No one shall speak more than twice on the same question.
6. Officers giving reports shall be limited to *five* minutes.
8. A time keeper shall notify each speaker when the allotted time has expired.
9. Only a voting member shall offer motions and vote. Motions must be in writing, signed by the mover, and presented to the recording secretary, when so requested by the Chair.
10. No announcements shall be made from the floor. All announcements of a vital nature shall be made from the platform after having been submitted in writing to the president, and with her approval.
11. Visitors are welcome at all the general sessions. All visitors and auxiliary members are requested to register.
12. The right to the floor may be granted to non-delegate members by consent of the Chair, or by majority vote of the delegates.

PLEDGE OF LOYALTY

I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals.

STATE OFFICERS

President .... Mrs. James Rich, Lexington
President-elect ... Mrs. J. Murray Kinsman, Louisville
First Vice-President .... Mrs. Paul Rizk, Grayson
Second Vice-President .... Mrs. J. Jack Martin, Tompkinsville
Third Vice-President ... Mrs. Ballard Cassady, Pikeville
Fourth Vice-President .... Mrs. Charles Kissinger, Henderson
Recording Secretary .... Mrs. Robert J. Salisbury, Mt. Sterling
Corresponding Secretary ...... Mrs. J. Andrew Bowen, Louisville
Treasurer .... Mrs. Graydon Long, Lexington
Parliamentarian ...... Mrs. Carlisle Morse, Louisville

ADVISORY COMMITTEE

Coleman C. Johnston, M.D., Chairman, Lexington
Hugh P. Adkins, M.D., Louisville
Jess T. Funk, Bowling Green

IMMEDIATE PAST PRESIDENTS

Mrs. Charles B. Johnson, Russell
Mrs. Earl W. Roles, Prospect
Mrs. Guy Morford, Owensboro

DISTRICT COUNCILORS

1st—Mrs. R. Ward Bushart, Fulton
2nd—Mrs. William W. Wainer, Providence
3rd—Mrs. James Freeman, Dawson Springs
4th—Mrs. J. M. Dishman, Greensburg
5th—Mrs. James E. Ryan, Louisville
6th—Mrs. D. T. Harvey, Glasgow
7th—Mrs. Harry J. Cowherd, Frankfort
8th—Mrs. Richard Rust, Fort Thomas
9th—Mrs. William Cartmell, Maysville
10th—Mrs. George Reed, Versailles
11th—Mrs. Arch B. Clark, Richmond
12th—Mrs. Barton L. Ramsey, Somerset
13th—Mrs. Elwood Kozee, Catlettsburg
14th—Mrs. George P. Archer, Prestonsburg
15th—Mrs. Keith Smith, Corbin

Co-Ordinator For Members-at-large — Mrs. R. E. Davis, South Carrollton

1963 STATE CONVENTION COMMITTEES

General Chairman .... Mrs. Thornton Scott, Lexington
Co-Chairman ...... Mrs. Richard Crutcher, Lexington
Registration .... Mrs. C. Edward Rankin, Fayette County, Lexington
Luncheon Chairman .... Mrs. Arnold Combs, Lexington
Decorations .... Mrs. Edward Ray Lexington
Tickets .... Mrs. William R. Willard, Lexington
Finance .... Mrs. T. Rothrock Miller, Lexington
Publicity .... Mrs. John B. Floyd, Jr., Lexington
Tours .... Mrs. O. T. Evans, Lexington
Mrs. B. T. Harris, Lexington
Official Hostesses
Chairman .... Mrs. Marion G. Brown
Mrs. Louis Bosworth
Mrs. Coleman C. Johnston
Mrs. John Prewitt
Exhibits .... Mrs. Irving Kanner, Lexington
Tellers .... Mrs. Hugh P. Adkins, Louisville
Mrs. J. Andrew Bowen, Louisville
Mrs. Charles B. Johnson, Russell
Pages .... Mrs. Charles Kavanaugh, Lexington
Mrs. Donald Howard, Frankfort
Mrs. E. P. Stevens, Owensboro
Time Keepers .... Mrs. David Cox, Louisville
Mrs. Charles Mahaffey, Danville

COMMITTEE CHAIRMEN

American Medical Education & Research Foundation
Mrs. C. Melvin Bernhard, Louisville
Benevolence .... Mrs. William M. Buttermore, Corbin
Bylaws and Parliamentarian ...... Mrs. Carlisle Morse, Louisville
Cancer .... Mrs. Joseph Parker, Lexington
Civil Defense .... Mrs. William G. Clouse, Richmond
Community Service .... Mrs. Charles F. Wilson, Pikeville
Doctor's Shop .. Mrs. Bacon L. Moore IV, Harrodsburg
Finance .... Mrs. David Cox, Louisville
Health Careers
Chairman, Mrs. George A. Buckmaster, Henderson
Co-chairman, Mrs. Hoyt Gardner, Louisville
Historian .... Mrs. Charles B. Johnson, Russell
International Health .... Mrs. Paul Lett, Lancaster
Legislation
Chairman, Mrs. G. David McClure, Louisville
Co-Chairman, Mrs. F. H. Hodges, Pikeville
McDowell House .... Mrs. Walker Owens
Mental Health .... Mrs. Joseph Parker, Lexington
Nominations .... Mrs. Guy Morford, Owensboro
Past Presidents .... Mrs. Guy Morford, Owensboro
Program .... Mrs. Robert C. Long, Louisville
Rural Health ... Mrs. Raymond Snowden, Hopkinsville
Safety .... Mrs. Dwight Blackburn
Tuberculosis .... Mrs. James Harris, Paducah

PAST PRESIDENTS

*1923—Mrs. Graham Lawrence, Shelbyville
*1924—Mrs. Graham Lawrence, Shelbyville
*1925—Mrs. Van Albert Stilley, Benton
*1926—Mrs. Van Albert Stilley, Benton
*1927—Mrs. William M. Martin, Harlan
*1928—Mrs. James Thomas Reddick, Paducah
1929—Mrs. P. E. Blackerby, Louisville
1930—Mrs. E. B. Houston, Murray
*1931—Mrs. George A. Hendon, Louisville
1932—Mrs. Arthur T. McCormack, Louisville
*1933—Mrs. Bartlett K. Menefee, Covington
*1934—Mrs. Joseph L. Greenwell, New Haven
1935—Mrs. Luther Bach, Florence
*1936—Mrs. Ernest Arthur Barnes, Albany
1937—Mrs. Stephen C. McCoy, Louisville
*1938—Mrs. Harlan Usher, Sedalia
1939—Mrs. Reasor T. Layman, Elizabethtown
1940—Mrs. John M. Blades, Butler
*1941—Mrs. John G. South, Frankfort
1942—Mrs. John B. Floyd, Richmond
1943—Mrs. Octavus Dulaney, Louisville
*1944—Mrs. Eleanor Hume Offutt, Frankfort
1945—Mrs. Shelby Carr, Richmond
1946—Mrs. Elmer L. Henderson, Louisville
1947—Mrs. Walker Owens, Mt. Vernon
1948—Mrs. R. Haynes Barr, Owensboro
1949—Mrs. Elbert W. Jackson, Paducah
1950—Mrs. Clark Bailey, Harlan
1951—Mrs. John S. Harter, Louisville
1952—Mrs. David Woolfolk Barrow, Lexington
1953—Mrs. Clyde C. Sparks, Ashland
1954—Mrs. Karl D. Winter, Louisville
1955—Mrs. R. Ward Bushart, Fulton
1956—Mrs. Charles B. Stacy, Pineville
1957—Mrs. J. Andrew Bowen, Louisville
1958—Mrs. Jess T. Funk, Bowling Green
1959—Mrs. Charles B. Johnson, Russell
1960—Mrs. Earl W. Roles, Louisville
1961—Mrs. Guy Morford, Owensboro

ORGANIZATION SECTION

Norman A. Welch, M.D., left, new president-elect of the American Medical Association, and Milford O. Rouse, M.D., Dallas, Tex., new speaker of the AMA House of Delegates, are pictured congratulating one another during the 112th Annual Meeting of the AMA held in Atlantic City in June.

Dr. Welch to Head AMA in 64-65 Dr. Annis Installed as Pres.

Norman A. Welch, M.D., Boston, a long-time foe of socialized medicine, was named president-elect of the American Medical Association by the House of Delegates of the AMA during the June 20 session of the four-day annual meeting held in Atlantic City. Elected speaker of the AMA House of Delegates was Milford O. Rouse, M.D., Dallas, Tex.

Dr. Annis

Edward R. Annis, M.D., Miami surgeon, was installed as the 117th president of the AMA on June 18. He replaced George M. Fister, M.D., of Ogden, Utah, outgoing president.

Doctor Annis served as 1962 chairman of the AMA's National Speakers Bureau, and has won prominence as a speaker and debater on behalf of organized medicine. He has addressed Kentucky physicians at various meetings, including the KSMA 1961 Annual Meeting.

Doctor Welch, who will take office next June, was for four years speaker of the AMA House of Delegates, and has been active in Blue Shield Plans on both state and national levels. He is a graduate of Harvard Medical School and limits his practice to internal medicine. Doctor Welch spoke at a recent KSMA Interim Meeting.

The new speaker of the House of Delegates, Doctor Rouse, an internist, is a past president of the Southern Medical Association, and has been vice-speaker of the House for the past few years. He is also active in the affairs of the Texas Medical Association.

Governor Combs Named Trustee Of Hospital Board

The Honorable Bert T. Combs, Governor of Kentucky, was named July 19 as one of eleven trustees selected to date of the Appalachian Regional Hospitals, Inc., the group that will soon take over operations of five former UMWA hospitals in Hazard, Harlan, Whitesboro, McDowell and Middlesboro.

Headquarters of Appalachian Regional Hospitals for the present time will be in Harlan, where Mr. Robert Selwyn, the administrator of the Harlan Memorial Hospitals, will act as resident agent for the new body.

In addition to Governor Combs, other trustees named to the Hospital Board are: the Honorable Edward Hill, circuit judge of Harlan; Maxwell P. Barret, Hazard attorney; Maurice Henry, publisher of the Middlesboro *Daily News;* Mrs. Harry M. Caudill, Whitesburg; James A. Moak, Lexington, executive secretary of the Kentucky Association of Christian Churches; David K. Heydinger, M.D., Columbus, O., a member of the Board of National Missions of the United Presbyterian Church; D. Allan Locke, Briarcliff Manor, N. Y., treasurer of the Board of Missions; Robert C. Millar, administrator of the Abbott Hospital in Minneapolis; Kenneth G. Neigh, general secretary of the Board of National Missions, and Lon B. Rogers, Pikeville attorney.

Appalachian Regional Hospitals, Inc., came into being on June 28, in time to receive a $3.9 million grand from the Area Redevelopment Administration before the federal budget year closed June 30. Application will be made later for a second ARA grant to purchase five remaining UMW hospitals in Pikeville and Williamson, Ky., Wise, Va., and Man and Beckley, W. Va.

REGISTRATION DEADLINE SEPT. 6

September 6 will be the last day for voter registration for the November 5 general election in Kentucky. In addition to the important gubernatorial election, Kentucky voters will be electing 19 state senators, and state representatives from all 100 districts.

The Kentucky State Medical Association wishes to remind all its members who are not properly registered to do so prior to September 6.

New Counties Participating In Auto Injury Study

Phase three of an intensive three-year research study aimed at making automobiles safer began August 1 in Kentucky.

This third six-month phase of the program will take place in Carroll. Gallatin, Henry, Oldham, Owen, Trimble and Caldwell, Christian, Crittenden, Hopkins, Muhlenberg, Todd and Webster counties.

Sponsored by the KSMA, the Kentucky State Department of Health, and the Kentucky Hospital Association in cooperation with Cornell University, purpose of the study is to obtain reliable data on the frequency, nature, and specific cause of injury to passenger car occupants in accidents.

If you are a physician in one of these counties you may be asked to participate in this interstate Automobile Crash Injury Research data-collecting project. When a passenger car occupant is killed or injured in this sampling area, the investigating State Police Officer will give the hospital or private physician a special medical form bearing the patient's name. Forms will be recorded on every tenth accident encountered by police officers. You will be asked to complete the form on the extent and nature of the injuries, no matter how minor.

Arthur H. Keeney, M.D., Louisville, KSMA Highway Safety Committee chairman, urges your cooperation in this effort to reduce deaths and injuries in future auto accidents. Doctor Keeney is the author of a special article containing more information on the study which appeared in the August, 1962 issue of the Journal.

Phase One of the program was conducted in Anderson, Bell, Fayette, Franklin, Knox, Harlan, Scott, Shelby, Spencer and Woodford counties. Counties which participated in Phase Two which ended on July 31 were: Allen, Barren, Boyd, Butler, Carter, Edmonson, Greenup, Hart, Lawrence, Logan, Simpson, and Warren.

Members of UMW Hospital Tour Voice Enthusiasm for Future

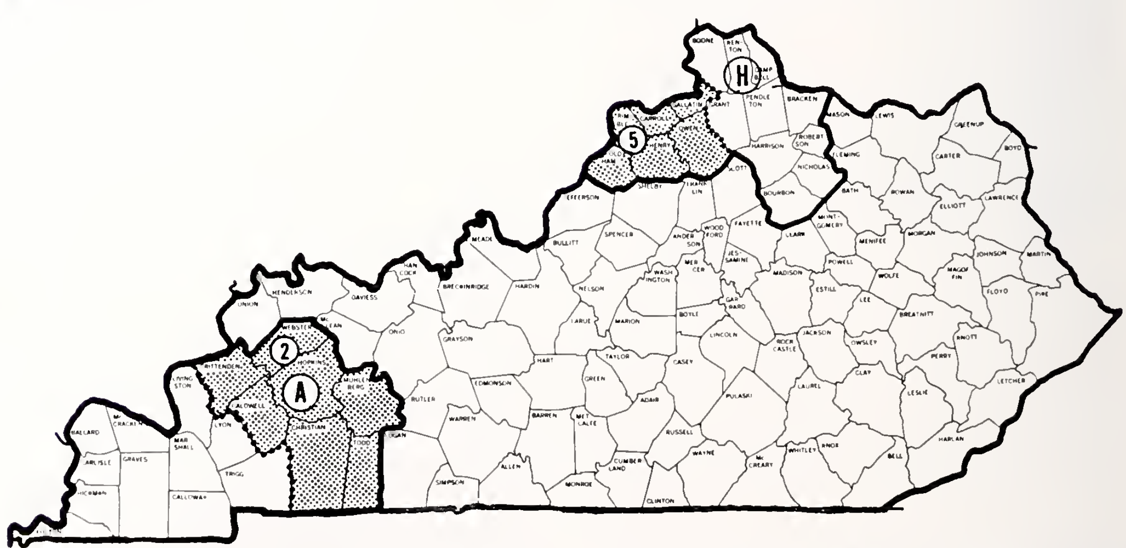
The KSMA Hospital Committee sponsored a five-meeting tour June 26, 27, and 28 through Southeastern Kentucky, where the UMWA hospitals to be transferred to the Appalachian Hospital Board are located, according to James B. Holloway, M.D., Lexington, Chairman of the committee.

In attendance at these meetings, in addition to Doctor Holloway, were Reverend Gordon Corbett, representing the Presbyterian Board of Missions; Eugene Rosenfeld, M.D., Hospital Consultant for the Presbyterian Board of Missions; Mr. Hasty Riddle, Executive Director of the Kentucky Hospital Association; and Mr. Bobbie R. Grogan of KSMA Headquarters. Approximately 90% of the private practicing physicians in the five communities of Pikeville, Hazard, Whitesburg, Harlan and Middlesboro also were present.

At each meeting a brief introduction and review of the historical happenings of the last six months was presented by the chairman of the KSMA Hospital Committee. Reverend Corbett spoke as to the purpose and attitudes of the Presbyterian Church, Doctor Rosenfeld presented his group's recommendations, and a discussion and question-and-answer period followed.

In each of the five meetings, there was grave concern demonstrated by the local physicians. There was a full and free interchange of thought, and the discussions apparently clarified many of the issues that were felt to be present.

The group making the trip returned home greatly impressed with the tremendous opportunities that are going to be open in Eastern Kentucky for the private practice of medicine. It was felt that it should be relatively easy to induce young men to go into this area to practice medicine, particularly with the fine facilities now at their disposal and with the return of normal physician-patient relations.



The third six-month phase of the Kentucky-Cornell Automobile Crash Injury Research project will be conducted in the darker areas shown on the map above. The study is being sponsored by the KSMA, the Kentucky State Department of Health, and the Kentucky Hospital Association in cooperation with Cornell University. The third sampling period began August 1 and will end January 31, 1964.

20 Medical Advisors Honored By Selective Service

Twenty Kentucky physicians who have each served more than twenty years as uncompensated medical advisors with the Selective Service System were among those honored with a banquet at Frankfort on June 13. Col. E. S. Stephenson, State Director of the Selective Service System, named the following physicians who have given their time and effort as medical advisors:

R. D. Sanders, M.D., Williamsburg; Charles B. Johnson, M.D., Russell; Walter L. O'Nan, M.D., Henderson; M. A. Coyle, M.D., Springfield; H. G. Wells, M.D., Georgetown; John T. Walsh, M.D., LaGrange; L. S. Hall, M.D., Campbellsville; Adam Stacy, Jr., M.D., Pineville; James Blackerby, M.D., Stanford.

Lloyd M. Hall, M.D., Salyersville; John D. Handley, M.D., Hodgenville; Bush A. Hunter, M.D., Lexington; W. Todd Jeffries, M.D., Columbia; Charles B. Stacy, M.D., Pineville; Ben F. Allen, M.D., Flemingsburg; George Bradley, M.D., Elizabethtown; T. R. Davies, M.D., Barbourville; A. B. Hoskins, M.D., Beattyville; Thomas H. Milton, M.D., Owensboro; and Garnett J. Sweeney, M.D., Liberty.

To Represent GP Section In AMA House of Delegates

Carroll L. Witten, M.D., Louisville, was named as a delegate to the American Medical Association by the AMA section on general practice at the annual meeting held in Atlantic City the third week in June.

Doctor Witten will serve out the unexpired term of Lester Bibler, M.D., Indianapolis, who was elected to fill one of the three newly created chairs on the AMA Board of Trustees. The term now being served by Doctor Witten, who was Doctor Bibler's alternate delegate, will expire December 31, 1964.

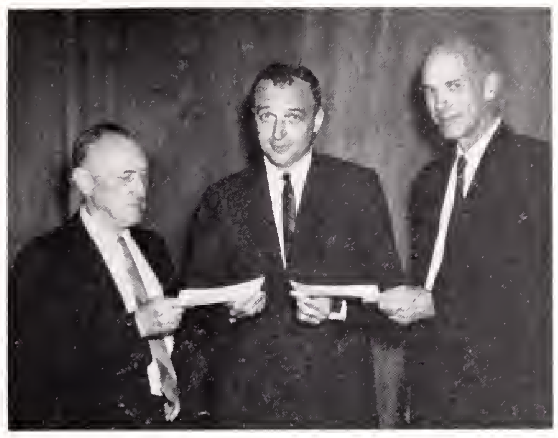
The section on general practice is one of the 19 specialty sections that are represented by delegates in the AMA House of Delegates. In addition to his recent appointment, Doctor Witten is speaker of the Congress of Delegates of the American Academy of General Practice.

Named to Indian Health Post

Doctor Witten recently received notice of his appointment as a special consultant to the Division of Indian Health of the United States Public Health Service. He will assist in hospital operations, patient care services, and the recruitment of medical staff.

The division is responsible for the medical and hospital care of American Indians and operates some 50 hospitals in the U.S.

George C. Barber, M.D., has begun general practice in the city of Morehead. Doctor Barber was graduated in 1960 from Bowman Gray College of Medicine and interned at William Beaumont General Hospital in El Paso, Texas.



J. Murray Kinsman, M.D., left, Vice-President of the University of Louisville, and William R. Willard, M.D., right, Dean of the University of Kentucky College of Medicine, accept checks for their medical schools from Walter I. Hume, Jr., M.D., Louisville, chairman of the Kentucky AMA—ERF committee. The checks, totaling $19,369.82, were presented during the June 27 meeting of the Council on Medical Education and Hospitals in Louisville.

Kentucky Medical Schools Receive Contributions

Kentucky's two medical schools received checks totaling $19,369.82 on June 27 from the American Medical Association Education and Research Foundation. The presentation was made during a meeting of the Council on Medical Education and Hospitals held at the KSMA Headquarters Office in Louisville.

Walter I. Hume, Jr., M.D., Louisville, chairman of Kentucky's AMA-ERF Committee, presented checks in the amount of $13,096.80 to J. Murray Kinsman, M.D., Vice-president of the University of Louisville, and $6,273.02 to William R. Willard, M.D., Dean of the University of Kentucky College of Medicine. (See picture). The checks were presented to the schools on behalf of the AMA-ERF and the physicians from Kentucky and all parts of the nation whose contributions made the grants possible.

These grants were part of the record $1,461,810.92 contributed in 1962 to AMA-ERF for medical schools by physicians and their families throughout the country. Efforts of the Woman's Auxiliary of the AMA provided $252,996.64 of the total amount.

A contributing physician may designate a specific school to receive his gift, or he may give without designation and have his contribution distributed equally among all the U.S. medical schools.

Funds for medical schools is one of two major programs of AMA-ERF. The other is the Medical Education Loan Guarantee Program, through which AMA-ERF underwrites low-interest bank loans to medical students, interns, and residents, to help them meet essential training and living expenses.

Robert Coleman, M.D., Hopkinsville, was recently appointed to the State Hospital Commission by Governor Bert T. Combs. Doctor Coleman is a radiologist at Jenny Stuart Hospital in Hopkinsville.

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Brightens mood...relaxes tension

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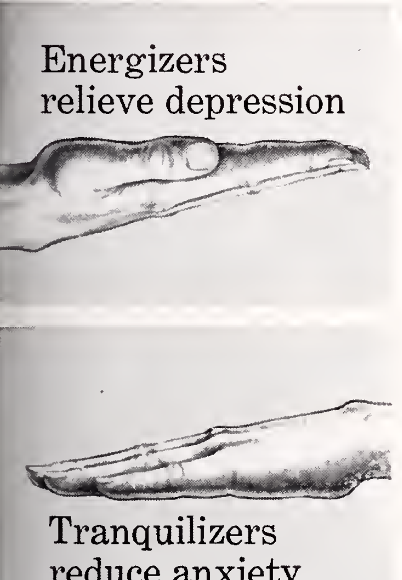

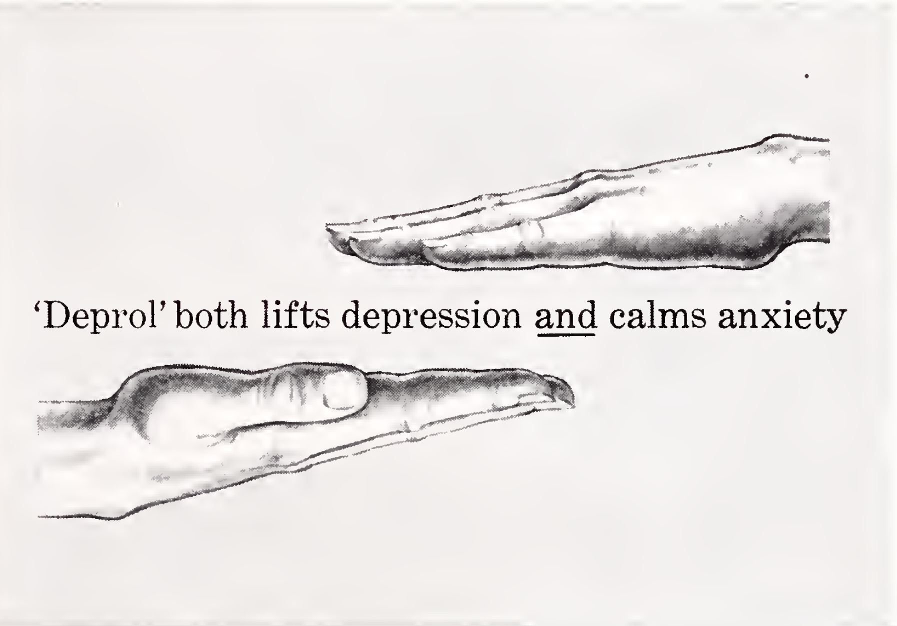

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meprobamate 400 mg.
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MEDICAL SCHOOL NEWS

Canadian M.D. Named New Head of U of L Heart Surgery

Allan M. Lansing, a Canadian who graduated from the University of Western Ontario in 1953, has assumed the major responsibilities for cardiovascular surgery at the University of Louisville School of Medicine.

As associate professor of surgery, he replaces Alex Haller, M.D., who resigned to accept a position at Johns Hopkins School of Medicine in Baltimore. Doctor Lansing was graduated from medical school magna cum laude. Selected as a Markle Scholar in 1961, in 1962 he was named outstanding medical teacher by students of Western Ontario where he taught for two years. He will be responsible for cardiovascular surgery at Children's Hospital, Louisville General Hospital, and Veterans Hospital.

Heart Research Grants

Four grants totalling $27,555 for heart research in Kentucky were announced recently by the American Heart Association. They are all renewals for continuing investigations.

Following are the recipients and amounts received: Borys Surawicz, M.D., associate professor and chief of the cardiovascular section, University of Kentucky School of Medicine, $6,490 for studies on abnormalities of heart rhythm; Peter K. Knoefel, M.D., chairman of the department of pharmacology, University of Louisville School of Medicine, $3,740 to study the mechanism by which the kidney eliminates certain nitrogen compounds from the blood; K. C. Huang, M.D., associate professor of pharmacology, University of Louisville School of Medicine, and Doctor Knoefel $6,050 to study flux movement of organic acids in kidney cells; and Robert S. Levy, Ph.D., assistant professor of biochemistry, University of Louisville School of Medicine, $11,275 to study an enzyme concerned with hardening of the arteries.

U.K. Professor Given "Golden Apple" Award

Tihamer Z. Csaky, M.D., professor and chairman of the department of pharmacology, was chosen "The Outstanding Pre-Clinical Instructor," by the sophomore medical students of the U. of K. chapter of the Student American Medical Association.

Richard Geist, junior medical student and chairman of the award committee, presented Doctor Csaky with a "Golden Apple" plaque at the College Of Medicine student-faculty dance on May 25.

This is the first year that the award has been given, but from now on SAMA, representing the student body of the College of Medicine, will present two such awards, one to an outstanding preclinical instructor, and the other to the outstanding clinical instructor.

Both awards are based on lecture and teaching ability, preparation of material, presentation, interest and knowledge of the subject and organization.

Doctor Csaky is a native of Maramarossziget, Hungary, and received an M.D. degree from the University of Budapest.

Grant For TB Program

Four University of Kentucky medical students will spend the summer in Martin County for the purpose of establishing a model tuberculosis eradication program in a rural community. The program is being supported by a $2,400 grant from the Kentucky Tuberculosis Association. Kurt Deuschle, M.D., chairman of the department of community medicine at U.K., is director of the project.

Pulmonary Disease Center Established at U. of L.

A new center for the study of pulmonary diseases opened July 1 at the University of Louisville School of Medicine under the direction of William H. Anderson, M.D., formerly director of the cardio-pulmonary laboratory at Harlan Memorial Hospital, Harlan.

The purpose of the pulmonary facility is to: 1. Serve as a center from which medical students will be taught the diagnosis and treatment of pulmonary diseases and clinical pulmonary physiology; 2. Provide the hospital staff (Louisville General Hospital) and patients with a facility for the routine testing of pulmonary function; 3. Provide a center where significant research programs in pulmonary diseases and pulmonary physiology can be undertaken.

Establishment of the facility was made possible by a grant of $22,500 over a five-year period by the Kentucky Tuberculosis Association and its local affiliates, and the American Thoracic Society. The amount will be supplemented by the University.

Dr. Anderson, a native of West Virginia, has rereceived an appointment as associate professor of medicine. He is a graduate of the University of Chicago Medical School and served his residency in internal medicine and another year in chest diseases at the U.S. Public Health Service hospitals in Staten Island and Brooklyn, N. Y.

Doctor and Mrs. Kinsman Honored

J. Murray Kinsman, M.D., and Mrs. Kinsman were honored June 1 at a reception given by U. of L. President and Mrs. Philip Davidson and the Board of Trustees of the University of Louisville. The occasion was that of Doctor Kinsman's retirement after 14 years as Dean of the Medical School, and his appointment as Vice-President of the University.

Members of the Medical School Faculty presented Doctor and Mrs. Kinsman with a gift of a silver tray, goblets and pitcher. Announcement was made of the establishment of the "Kinsman Scholarship Fund," named in honor of Doctor Kinsman. The scholarship will be used for Medical Students. The reception was attended by 750 people.

Digest of the Minutes of the KSMA Board of Trustees Meeting

June 6, 1963

The Board of Trustees of the Kentucky State Medical Association met on June 6 in the Board Room of the headquarters office in Louisville.

After learning that the members of the Johnson, Pike, Perry, Letcher, Floyd and Magoffin County Medical Societies had extended an invitation to the Association to hold its 1964 Interim Meeting at the Jenny Wiley State Park at Prestonsburg, the Board unanimously voted to do this on Thursday, April 23, 1964.

The Board accepted a proposed expense report form for members traveling at the Association's expense, which was prepared by the Association's auditor and which will be acceptable to the Internal Revenue Service.

The Board also provided for the procedures that members traveling to national meetings at Association expense shall follow in reporting on their activities.

Recommendations of the KSMA Memorials Commission were considered and approved. These recommendations included providing the mechanism for contributions in certain areas at the Headquarters Office.

After hearing the Reverend Dr. Paul B. McCleave, director of the AMA's Department of Medicine and Religion, explain the AMA's recommendation, the Board unanimously voted to appoint such a committee in Kentucky and named the five members of the committee it has requested to carry on the work.

The chairman of the Budget Committee presented the recommendations for the budget for the 1963-64 associational year, after explaining that these recommendations had been drafted in a day-long meeting of the Budget Comittee and considered at length by the Executive Committee of the Board. After discussion, these recommendations were approved without dissent. The Board then considered the proposal of the KSMA Advisory Comission to the Blue Shield for the formation of what is to be known as the KSMA Insurance Review Board.

It was indicated that the formation of the Insurance Review Board would provide physicians a method of combating inflated medical fees, would give the insurance industry protection, as well as the physicians protection from certain insurance companies.

Following discussion and certain minor amendments, the Board passed the motion calling for the implementation of the recommendation. (More will appear in a subsequent issue of The Journal on this important activity following the appointment of the Board and its activation). At this point, developments in the negotiations between the Presbyterians and the United Mine Workers hospital chain were discussed, and Governor Bert T. Combs appeared before the Board. (See July issue of Journal of KSMA for details)

The Board then heard the chairmen of various trustee district grievance committees report on activities in their district. The Board then voted not to act favorably on bids to provide linings for the drapes in the Board Room at the Headquarters Office.

The Board unanimously voted to send congratulations to Fred C. Rainey, M.D., Elizabethtown, who has recently been elected as the new president of the Kentucky Junior Chamber of Commerce.

The Board voted upon a recommendation of the Kentucky Society of Anesthesiologists to place one of its members on the Infant and Maternal Committee.

County Society Reports

Shelby — Oldham — Henry

U. R. Ulferts, M.D., Louisville, addressed the members of the Shelby-Oldham-Henry Medical Society at the April 25 meeting at the Old Stone Inn. The topic of Doctor Ulferts' discussion was "Abnormal Pregnancy." Fifteen members and guests attended the meeting.

Webster

Webster County physicians held a dinner meeting on May 1 at the Hillcrest Restaurant in Sebree for the purpose of reviving the Webster County Medical Society.

Officers elected to head the group were John A. Logan, M.D., Sebree, president, and Ed Waltrip, M.D., Providence, secretary-treasurer. Paul Taylor, M.D., Providence, was named liaison officer from the society to the State Department of Health. E. W. Atherton, M.D., Clay, was named delegate to the Kentucky State Medical Association. Doctor Taylor is alternate delegate.

Post Graduate Course

A post graduate course in gastroenterology on Diseases of the Small Intestine will be presented at the Cleveland Clinical Educational Foundation on October 2 and 3. H. Marvin Pollard M.D., and G. Gordon McHardy, M.D., will be the guest speakers. Further information may be obtained by writing to Charles H. Brown, M.D., Cleveland Clinic, 2020 East 93rd Street, Cleveland 6, Ohio.

AMA Gives Special Award

The Board of Trustees of the American Medical Association presented a special citation to Mr. C. P. Loranz of Birmingham, Ala., former secretary- manager of the Southern Medical Association, during the first session of the House of Delegates on June 17 in Atlantic City, as a tribute to his unique contribution to medicine.

Digest of Actions of AMA House of Delegates

Establishment of a new Institute for Biomedical Research, enlargement of the Sections and Scientific Program of the AMA, enlargement of the Board of Trustees and the development of a pension plan by the AMA for its members, were among some of the more important actions taken by the House of Delegates of the AMA at its 112th Annual Meeting June 16-20 in Atlantic City, N.J.

The AMA 1963 Distinguished Service Award was voted to Dr. Lester R. Dragstedt of Gainesville, Florida, research professor of surgery at the University of Florida School of Medicine, for his achievements in the fields of education, research and practicing surgery.

The House adopted amendments to the Constitution and Bylaws designed to implement the recommendations presented in June, 1962, by the Ad Hoc Committee on the Board of Trustees. The changes will increase the size of the Board from 11 members to 15 members, by adding three elected trustees and including the immediate past president for a one-year term. The amendments also set the term of office for elected Board members at three years and limit the number of terms to three, for a maximum total of nine years service.

In considering the report of the Ad Hoc Committee to study the Board of Trustees Report on the Sections and Scientific Program of the AMA, originally presented at the 1962 Clinical Meeting in Los Angeles, the House disagreed with some recommendations in both of those reports.

A major change was the House decision that all section officers—chairman, vice chairman, delegate, alternate delegate, secretary, assistant secretary and representative to the scientific exhibits—should be elected by members of the section and that no officers be appointed by the AMA Board of Trustees.

In another change, relating to nominations for specialty boards, the House approved the following recommendation: "The Committee of the Council on Scientific Assembly of the appropriate section shall nominate the AMA representatives to serve on the medical specialty certifying board. These nominations shall be submitted to the Board of Trustees."

The House also commended the Board of Trustees for its recommendation that a national forum be sponsored by the AMA in which representatives of national medical specialty societies and the Academy of General Practice will participate. The Board of Trustees was directed to implement this suggestion as early as possible.

The House disapproved the report of the Council on Medical Service and the Council on Medical Education and Hospitals on Compensation of House Officers. In so doing, it adopted the following statement:

"We therefore recommend that in view of the overwhelming opposition to the basic proposal contained in the report of the Council on Medical Service and the Council on Medical Education and Hospitals, the AMA record itself as opposed to any system or program by which any part of an intern's or resident's salary is paid out of fees collected by the attending physician or out of fees collected under any type of medical-surgical insurance coverage."

The House, while declaring that the joint council report "represents a well-intentioned effort to find a solution to a most difficult, if not impossible, problem," recommended that any future proposals on the compensation of house officers be thoroughly studied by the Law Department and Judicial Council before submission to the House of Delegates.

In another action, related to the controversial "25% rule," the House approved a revision of the Essentials of an Approved Internship which deletes the requirement for any stated proportion of foreign medical graduates and graduates of American and Canadian medical schools as an essential feature of any internship program.

In acting upon two reports from the AMA Education and Research Foundation, the House approved the Foundation's announcement that it will establish and operate a new Institute for Biomedical Research.

The Institute will concern itself with intensive and fundamental study of life processes particularly as related to intracellular mechanisms. It will be composed of groups of dedicated, imaginative workers who are capable of significant scientific achievements through the interaction of their intellects and experiences, with unmatched facilities and maximum freedom from external pressures.

The House approved establishment of an AMA physicians' pension plan under the provisions of the Self-Employed Individuals' Retirement Act of 1962, and noted that the Board of Trustees will make every effort to begin operation of the plan before the end of 1963 so that physicians will be able to participate this year.

The plan will be open to all AMA members and their employees who can qualify under the Act, Public Law 87-792 (Keogh Law).

The House agreed with a Board of Trustees report which concluded that the AMA should defer any definitive statement regarding the relationship of tobacco and disease. The report pointed out that the AMA is continuing its study of this important subject and is merely deferring any public pronouncement pending the availability of more information, including whatever may come from the study of a committee appointed by the United States Public Health Service.

Miscellaneous Actions

In considering a wide variety of resolutions and reports, the House also:

Disapproved a Judicial Council opinion on the dispensing of glasses by ophthalmologists and reaffirmed the Council's interpretation of Section 7 of the Principles of Medical Ethics, as reported in the November 15, 1958, issue of the Journal of the American Medical Association.

Approved a Judicial Council opinion on physician

safely
indicated
–even when **OSTEOPOROSIS** is present

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In each persian-rose enteric-coated tablet: potassium salicylate, 0.3 Gm.; potassium para-aminobenzoate, 0.3 Gm.; ascorbic acid, 50 mg.

1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

Precaution: Occasionally, mild salicylism may occur, but this responds readily to dosage adjustment. In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Supply: Bottles of 100 and 500 enteric-coated tablets.

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(the new, convenient way to prescribe Pabalate-Sodium Free)

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ownership of drugstores, drug repacking houses and pharmaceutical companies.

Approved of AMA participation in the recent formation of a Joint Commission on Medicine and Pharmacy.

Agreed with the Council on Legislative Activities that the House should take no official position on the "Liberty Amendment" but should call it to the attention of individual physician citizens.

Disapproved of federal funds for staffing new community mental health centers.

Took a position opposing the student loan provisions of the Health Professions Educational Assistance Act of 1963.

Urged all state and county medical societies to adopt and activate all phases of "Operation Hometown."

Recommended that local medical societies in the vicinity of medical schools assume the responsibility of establishing and maintaining clear lines of communication with medical students.

Adopted the recommendations of the Committee to Study the Joint Commission on the Accreditation of Hospitals and suggested that the committee's report be distributed to constituent and component societies and hospital chiefs of staff.

Approved an alteration in the Association Bylaws which states: "The Council on Medical Education and Hospitals shall consist of ten Active or Service members at least one of whom shall be a private practitioner of medicine who is not a faculty member of a medical school nor a member of a staff of a hospital associated with a medical school or university."

Commended the American Farm Bureau for its vigorous leadership in opposing unwarranted government interference and regulation.

Urged the widest dissemination to AMA members of a joint report by the AMA Council on Mental Health and the National Academy of Sciences-National Research Council on The Use of Narcotic Drugs in Medical Practice and the Medical Management of Narcotic Addicts.

Directed the Speaker of the House to appoint an ad hoc committee to study the size, make-up and functions of the House of Delegates, its councils, sections and committees and to report its findings in June, 1964.

Seek Money for Bailey Fund

The need for additional capital for the Clark Bailey Memorial Fund which provides scholarship help for medical students was announced at a recent meeting of the Harlan County Medical Society by John H. Willard, M.D., Harlan.

Since the fund was established in memory of the late Doctor Bailey in 1957, loans totaling $5,000 have been made to two medical students from Harlan County—one at U of L and one at Tulane. Repayment of these loans will not start until 1969. Present fund capital is almost depleted. It is hoped to add $6,000 to the Fund in the next five years.

In Memoriam

C. W. DOWDEN, M.D.
Louisville
1880-1963

Chauncey Warring Dowden, M.D., 82, Louisville internist for nearly 50 years, died July 17 at Waverly Hills Geriatrics Center. A native of Indiana, Doctor Dowden received his M.D. from the Louisville Medical College in 1904. Among his many professional affiliations. Doctor Dowden was an emeritus member of the Kentucky State Medical Association and a former governor of the Kentucky Chapter, American College of Physicians.

A. DAVID WILLMOTH, M.D.
Louisville
1875-1963

A David Willmoth, M.D., 87, Louisville surgeon, died July 1 at St. Anthony Hospital, where he had been a patient since January. Doctor Willmoth, who had been on the staff of St. Anthony since graduation from Louisville Medical College in 1896, was an emeritus member of the Kentucky State Medical Association. He had taught at medical schools in Kansas City and Los Angeles, and at three of the five medical colleges which existed in Louisville at the turn of the century.

W. P. K. HOWARD, M.D.
Highsplint
1884-1963

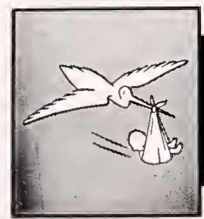
William P. K. Howard, M.D., 78, a general practitioner in Harlan County for more than 50 years, died June 28 following a brief illness. A graduate of Lincoln Memorial University, Doctor Howard graduated in 1912 from the University of Louisville Medical Department.

WILLIAM V. EATON, M.D.
Paducah
1903-1963

William V. Eaton, M.D., 59, Paducah general practitioner for 33 years, died unexpectedly at his home on June 9. Doctor Eaton, a graduate of Vanderbilt University, received his M.D. from Tulane University School of Medicine in 1928. A native of Paducah, he had practiced in that city since 1930.

EDWARD J. NESTLEY, M.D.
Covington
1896-1963

Edward J. Nestley, M.D., 66, Covington general practitioner, died June 16 at Booth Hospital in Covington following a heart attack. Doctor Nestley received his M.D. from the Eclectic Medical College in Cincinnati in 1918. He was a veteran of World War I.



From the files of the

COMMITTEE FOR THE

STUDY OF MATERNAL MORTALITY

CASE # 95—This 34 year old white gravida 9, para 7, ab 1, was first seen on May 25, 1960 at 20 weeks' gestation with a history of spontaneous rupture of the membranes. The patient was examined in the emergency room by her physician and sent home without treatment. No uterine contractions were noted. Objective evidence of ruptured membranes was neither confirmed nor denied on the record.

The patient next consulted her physician on the evening of May 27, 1960, shortly after the onset of cramping abdominal pain. When questioned, she admitted having had chills and feverish sensations ever since the previous examination. Antibiotic medication of unspecified dosage and type was prescribed.

At 10:00 p.m. on the evening of May 28, 1960, the patient was admitted to the hospital in labor. On clinical examination, she appeared to be about 22 weeks pregnant. The blood pressure was 70/50. No fetal heartbeat could be ausculted. Immediately after examination, she was given 50 mg. of Demerol and 1/200 gr. of scopolamine. She was apparently in the second stage of labor, as premature female twins weighing 1 lb. 9 oz. and 1 lb. 7 oz. respectively were delivered spontaneously at 10:22 and 10:23 p.m. An ampoule of pitocin was administered intramuscularly immediately following delivery of the infants. An intact placenta was delivered by simple expression. It was noted that the placenta had a foul odor at the time of its expulsion. Just after delivery of the placenta, the blood pressure was 86/50. An intravenous infusion of 5% glucose in saline with 500 mg. of Achromycin was started, and blood was drawn for type and cross-match. Shortly after the infusion was begun, the blood pressure rose slightly, but shock levels persisted throughout the remainder of the downhill course. At 1:00 a.m. on the morning of May 29, 1960, 250 mg. of chloromycetin was administered. At 5:00 a.m., the blood pressure was 64/40, pulse 120, and temperature 100°. A 500 cc. transfusion was administered. Half an hour later, 1 gm. of chloromycetin was given intramuscularly. At 6:55 a.m., the blood pressure was 58/40; 0.1 mg. neosynephrine was given hypodermically. At 7:25 a.m., a glucose infusion with 4 cc. of Levophed was started. At 8:00 a.m. 100 mg. of Solu-cortef was added to an infusion consisting of 500 cc. of 5% glucose in saline. At 10:00 a.m., 4 cc. of Digoxin was given together with 1 cc. of Mercuhydrin. At 11:30 a.m., 1,000,000 units of penicillin were administered. Similar management continued throughout the afternoon and evening of May 29; by 7:30 p.m., the patient had received totals of 200 mg. of Solu-cortef, 2,000,000 units of aqueous penicillin, 0.5 gm. of Streptomycin, and 8 cc. of Levophed. The blood pressure was now 100/70; there was circumoral cyanosis, and the patient was restless and apprehensive. She refused to use the oxygen mask.

At 8:00 p.m., she complained of severe bearing down pains in the abdomen, and expelled a moderately large piece of placental tissue. By 8:30 p.m., the patient had stopped breathing and was being given artificial respiration. The apical heartbeat was inaudible. She was prounced dead at 9:30 p.m.

No autopsy was performed. The final recorded diagnoses were: (1) spontaneous abortion with sepsis; (2) endometritis; (3) hypotension; (4) acute congestive heart failure with probable adrenal failure; (5) pulmonary embolism due to sepsis.

COMMENT

This protocol illustrates graphically the clinical picture of septic shock in a patient with an infected abortion. This diagnosis should be entertained in any patient with evidence of infection and otherwise unexplained concomitant hypotension. The indicated therapy consists of combating shock, controlling infection, and administering adrenal corticoids. These therapeutic measures must be undertaken promptly and pursued vigorously; homeopathic doses are valueless. A potent vasopressor is essential for combating shock, and it must be administered in sufficient quantity and for a long enough time to produce effective maintenance of the blood pressure at normotensive levels. A serious problem arises when the patient becomes refractory to any given agent; constant vigilance and quick change of vasopressor agent are necessary to tide the patient over the acute hypotensive episode. In the patient in question, only token amounts of Levophed were given, and they produced no effect. Increased concentration or substitution of another vasopressor would seem to have been indicated.

Antibiotics must be given in massive doses. The choice of drugs in necessarily empirical, since there is no time to await the results of a blood culture drawn at the time of recognition of the syndrome. In the case reported, no antibotic was given in anything approaching adequate dosage. In many reported cases, Chloramphenicol, preferably by the intravenous route, appears to be the most effective antibiotic.

Although there is some doubt that patients with septic shock die primarily from adrenal failure, large doses of adrenal corticoids are coming to occupy a significant place in the management of these patients. In some respects, the clinical picture of septic shock resembles that of acute adrenal insufficiency, and in some of the autopsied cases, a Waterhouse-Friderichsen-like change has been noted in the adrenals. In addition, the steroids are known to subdue inflammation and the accompanying toxic

(Continued on Page 719)

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Whether your muscle-injury patient is a professional athlete or just a weekend golfer, you can expect rapid results with 'Soma' (carisoprodol).

This unique drug breaks up both muscle spasm and pain at the same time. Onset of action takes only 30 minutes, and your patient will usually begin to feel better within hours.

As Conant demonstrated in a study of 106 patients with musculoskeletal injuries, 88% of the patients treated with 'Soma' (carisoprodol) achieved good to excellent results. *(Clinical Medicine,* March, 1962.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely.

For severe athletic strains or everyday sprains, you can rely on 'Soma' (carisoprodol) to help speed recovery with notable safety.

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The muscle relaxant with
an independent pain-relieving action

Wallace Laboratories, Cranbury, New Jersey

KSMA Council and Committee Reports

Golf Committee

Kenton D. Leatherman, M.D., Chairman

Lexington **May 15, 1963**

At its recent meeting, the KSMA Golf Committee reviewed the procedures of past KSMA Golf Tournaments and announced that the 1963 tournament would be held at the Lexington Country Club.

To give every participant the same opportunity to win the tournament, members of the committee ruled that handicaps would be awarded by the Bankers System. It was voted to award permanent trophies in lieu of the traveling trophies that have been awarded in the past.

It was recommended by the committee that beginning with the 1964 Annual Meeting, one designated afternoon be set aside for golf and recreational activities at which time no scientific sessions be scheduled.

Council on Medical Services

Claude C. Waldrop, M.D., Chairman

Louisville **June 13, 1963**

Meeting for its second time this year, the Council again discussed the new Keogh Law (the Self-Employment Individual Tax Retirement Act). No definite action was taken, but the Council requested that the Headquarters Office maintain an information file on the new law for the purpose of providing information to the KSMA members on request.

The primary purpose of this meeting was to act on the final reports of the nine committees serving under the Council. These reports and the Council's action was forwarded to the Board of Trustees along with a recommendation concerning the resolution introduced by the Pike County Medical Society at the 1962 Annual Meeting and subsequently referred to the Council for study.

Mental Health Committee

Frank M. Gaines, Jr., M.D., Chairman

Louisville **May 29, 1963**

At its second meeting, the Mental Health Committee recommended to the Board of Trustees that KSMA sponsor a one-day Kentucky Congress on Mental Health jointly with the State Department of Mental Health and the Kentucky Psychiatric Association.

The Mental Health Committee also recommended that KSMA encourage the establishment of Mental Health Committees in county societies and went on record as being in favor of county medical societies taking some initiative in improving relations between physicians in state hospitals and those in nearby societies.

The committee's final recommendation concerned its desire for KSMA to express its approval of having legislation presented to the Kentucky State Legislature that would change the Medical Practice Act to make it possible for qualified foreign physicians to get a full license in Kentucky.

Diabetes Committee

Robert S. Tillett, M.D., Chairman

Louisville **June 12, 1963**

The Diabetes Committee held its first meeting of the year and recommended that promotion of the 1963 Diabetes Detection and Education Week be conducted has been done in the past.

The committee is hopeful that the follow-up on positive tests can be improved by securing the cooperation of the county diabetes chairman to request the name of the patient and his physician when the Urine Tests are collected.

The committee went on record as being in favor of co-sponsoring with a number of other organizations an exhibit in the Health-O-Drama Section of the 1963 State Fair for the purpose of giving free Diabetes Detection Tests.

School Health Committee

R. E. Davis, M.D., Chairman

Lexington **June 20, 1963**

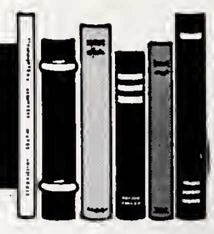
The KSMA School Health Committee, meeting for its third time this year, urged recognition of the Physical Education Program in Paducah for its excellence and expressed its desire that such a program be conducted throughout our state school system.

Members of the committee took final action in deciding to conduct three Athletic Injury Prevention Conferences during 1963. Local physicians will appear on the panel of these conferences which will be held in Newport, Louisville, and Paducah. The conferences will be held in conjunction with the Kentucky High School Athletic Association Football and Basketball Rules Clinics.

Marion A. Carnes, M.D., has joined the staff of the University of Kentucky Medical Center, it was announced recently. Doctor Carnes, who was formerly associated with the University of Mississippi Medical Center, was also in private practice in Nashville for a time. He is a 1949 graduate of the University of Tennessee College of Medicine. He completed his residency in anesthesiology at Vanderbilt University Hospital.

John A. Schremley, M.D., psychiatrist, has joined the faculty of the University of Kentucky Medical Center in Lexington. Doctor Schremley, who is also on the staff of the United States Public Health Service Hospital, is a 1957 graduate of the University of Vermont Medical School. He was a resident in psychiatry at the Institute of Living, the U.S. Public Health Service Hospital in Lexington, and at Boston City Hospital.

IN THE BOOKS



ENDOCRINE AND METABOLIC ASPECTS OF GYNECOLOGY: by Joseph Rogers, M.D.; published by W. B. Saunders Company, Philadelphia, 1963; pages, 189; price, $8.

Joseph Rogers, M.D., has done a commendable job of gathering together and neatly summarizing material pertinent to the endocrine and metabolic aspects of gynecology. This book, with approximately 180 pages, is written in a clear, concise manner and is the kind of book that is valuable to both medical student, practitioner and specialist. There is a good bibliography at the end of each chapter.

In this book one finds excellent material pertinent to the physiology and pathology of menstruation. A fine chapter on menstruation and systemic disease presents the effect of disorders of thyroid, liver disease, diabetes and other metabolic conditions on menstrual function. The induction and control of ovulation is discussed as well as the general problem of infertility.

Doctor Rogers says in the introduction, a short but reasonably comprehensive review of the various endocrine aspects of gynecology could find a place with the student and practitioner alike. It is the opinion of the reviewer that he has accomplished his purpose. The book is short, but Doctor Rogers has the ability to put much factual material in few words. It is interesting that Doctor Rogers is an internist and this emphasizes the great growth of this specialty of gynecologic endocrinology and the need for the practitioner to be adequately versed in this discipline.

John W. Greene, Jr., M.D.

CURRENT THERAPY 1963: edited by Howard F. Conn, M.D.; published by W. B. Saunders Co., Philadelphia, 1963; 775 pages; price, $12.50.

The busy practitioner frequently has need for accurate information about the current therapy of a wide variety of diseases and conditions that he encounters. This book is intended as such reference, and it fulfills its stated purpose quite adequately. Ready access to information on many subjects is available that could otherwise be found only after many hours spent in the library.

The material covered includes diseases of the various organ systems, as well as the infectious diseases, metabolic disorders, veneral diseases, allergic diseases, and physical and chemical injuries. The table of contents is divided into 16 sections, which greatly facilitate the use of this book.

The more than 300 different authors are actively engaged in the treatment of the diseases about which they write. The section on the nervous system is outstanding in its completeness. Throughout this volume the contributing authors strive to give a balanced viewpoint. In a few instances, however, where a choice of therapeutic agents is available, the author has limited his discussion to his personal preference. For example, Warfarin is the only anticoagulant discussed in the treatment of thrombophlebitis, and Librium the only tranquilizer suggested for the treatment of acute alcoholic intoxication. One would also have expected some mention of the treatment of peptic ulcerative diseases by gastric freezing, if only for the sake of completeness.

The absence of references in a volume such as this is understandable, but there are times when it is regrettable. The use of castor oil as a locally applied "soothing antiseptic" agent to the eye that received an acid burn, is one instance in which a suitable reference would have been welcome.

While Current Therapy 1963 is the 15th in the annual series of this publication, each volume is completely rewritten, and is not a revision of previous volumes. This orientation by the editor insures the current usefulness of this volume in an era of great strides in medical research and its application to therapy.

It is a useful and generally sound volume for busy doctors.

Martin H. Boldt, M.D.

MEDICINE IN THE UNITED STATES AND THE SOVIET UNION: by George A. Tabkov, M.D.; published by The Christopher Publishing House, Boston, 1962; 310 pages; price $4.95.

Doctor Tabakov, a pediatrician, writes this comparison of United States and Soviet medicine with a background in medical education and practice in Bulgaria, both before and during Soviet control of that country. The past five or more years in the U.S.A. rounds out his medical experience and makes his comparison especially valuable.

In this volume, Doctor Tabakov points out a tremendous spread in competence between the few very learned academicians and the vrachi (physicians), many in number, poor in quality. Communist ideology stifles medicine in all phases of education, practice and research. Worship of Pavlov's nervism exemplifies their blindness to universally accepted scientific explanations. Most of Russian basic and clinical sciences are compared in great detail with American, exact references given in all cases.

On the whole, Americans can take heart in Doctor Tabakov's mind for possessing a superior medical system from nearly every point of view. However, he displays concern over many weaknesses that could be vital in the struggle with an enemy that has vowed to "bury" us.

Thomas N. MacKrell, M.D.

94 Kentucky Physicians Register at AMA Annual Meeting

According to Lloyd W. Prang, manager of the Physicians' Records section of the American Medical Association, 94 Kentucky physicians are listed as having registered at the 112th Annual Meeting of the AMA in Atlantic City June 16-20.

Following is a complete list of Kentucky registrants:

Samuel M. Adams, M.D., London
Andres Alonso, M.D., Harlan
George P. Archer, M.D., Prestonburg
Maurice Best, M.D., Louisville
Warren Borsch, Jr., M.D., Louisville
J. Andrew Bowen, M.D., Louisville
George F. Brockman, M.D., Greenville
W. L. Broghamer, Jr., M.D., Louisville
Charles G. Bryant, M.D., Louisville
W. F. Chumley, M.D., Beaver Dam
L. C. Ciaramelli, M.D., Lexington
Jerome E. Cohn, M.D., Lexington
Carl C. Cooper, Jr., M.D., Bedford
Albert B. Corzo, M.D., Louisville
David M. Cox, M.D., Louisville
M. R. Cronen, M.D., Louisville
Leighton L. Cull, M.D., Frankfort
Elbert L. Dennis, M.D., Louisville
Charles H. Duncan, M.D., Louisville
B. Eiseman, M.D., Lexington
Henry Evans, M.D., Harlan
Earl J. Farrell, M.D., Newport
M. T. Fliegelman, M.D., Louisville
Hoyt D. Gardner, M.D., Louisville
J. Thomas Giannini, M.D., Louisville
George Gumbert, M.D., Lexington
Michael M. Hall, M.D., Campbellsville
James D. Hancock, M.D., Louisville
Elton Heaton, M.D., Louisville
August Helmbold, M.D., Newport
George Hermann, M.D., Ft. Thomas
A. C. Hohn, M.D., Harlan
John C. Hill, M.D., Louisville
Benjamin B. Jackson, M.D., Louisville
V. A. Jackson, M.D., Clinton
Charles B. Johnson, M.D., Russell
M. D. Klein, M.D., Shelbyville
J. Murray Kinsman, M.D., Louisville
Lloyd O. Larsen, M.D., Lexington
Robert C. Long, M.D., Louisville
Robert W. Lykins, M.D., Louisville
Thomas R. Marshall, M.D., Louisville
Homer B. Martin, M.D., Louisville
Carl E. Marusak, M.D., Ft. Knox
Lloyd D. Mayer, M.D., Lexington
W. P. McKee, Jr., M.D., Louisville
Guy Morford, M.D., Owensboro
Carlisle Morse, M.D., Louisville
R. J. Muelling, Jr., M.D., Lexington
Wyatt Norvell, M.D., New Castle
Earl P. Oliver, M.D., Scottsville
J. Vernon Pace, M.D., Paducah
Lee Palmer, M.D., Louisville
William P. Peak, M.D., Louisville
R. J. Phillips, Jr., M.D., Owensboro
Paul A. Pichardo, M.D., Glasgow
Nicholas J. Pisacano, M.D., Lexington
John C. Quertermous, M.D., Murray
Ben A. Reid, M.D., Louisville
James S. Rich, M.D., Lexington
Albert H. Robinson, M.D., Pikeville
Earl W. Roles, M.D., Louisville
Gradie R. Rowntree, M.D., Louisville
Marjorie Rowntree, M.D., Louisville
William T. Rumage, Jr., M.D., Louisville
Edward I. Rustin, M.D., Pikeville
Carl E. Rutledge, Jr., M.D., Louisville
John E. Ryan, M.D., Louisville
N. A. Saliba, M.D., Louisville
Otto H. Salsbery, M.D., Covington
Plutarco A. Santana, M.D., Harlan
Joseph H. Saunders, M.D., Lexington
Philip Schmidt, M.D., Fort Knox
Thomas M. Scruggs, M.D., Fort Knox
Jane B. Sears, M.D., Lexington
Kenneth L. Sears, M.D., Lexington
Horace H. Seay, M.D., Louisville
S. A. Shaffer, M.D., Ashland
Edward C. Shrader, M.D., Louisville
H. Tod Smiser, M.D., Cynthiana
Truman S. Smith, M.D., Madisonville
William G. Smith, M.D., Lexington
H. South, M.D., Louisville
W. W. Spalding, M.D., Louisville
Harry J. Stone, M.D., Ashland
George C. Stege, M.D., Louisville
Richard C. Turrell, M.D., Louisville
J. W. Urton, M.D., Louisville
William P. Vonder Haar, M.D., Louisville
Ralph E. Westervelt, M.D., Whitsburg
William R. Willard, M.D., Lexington
Charles F. Wilson, M.D., Pikeville
Carroll L. Witten, M.D., Louisville
Frank L. Yarbrough, M.D., Owensboro

KSMA Staff Named

A new committee to study annual meetings has been appointed by the Medical Society Executives Association. KSMA Executive Secretary J. P. Sanford will serve as chairman of the new group.

Robert G. Cox, also of the KSMA staff, was appointed to serve on the MSEA's Committee on Continuing Education.

Albert H. Joslin, M.D., has entered the practice of urology in Owensboro. A 1954 graduate of the University of Louisville School of Medicine, Doctor Joslin was engaged in general practice at Beaver Dam before becoming a resident at Norton Memorial Infirmary in Louisville in 1959.

ANESTHESIOLOGIST-Board qualified, desires to relocate because of unfavorable local conditions. Reply to:

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3532 Janet Avenue, Louisville, Ky.

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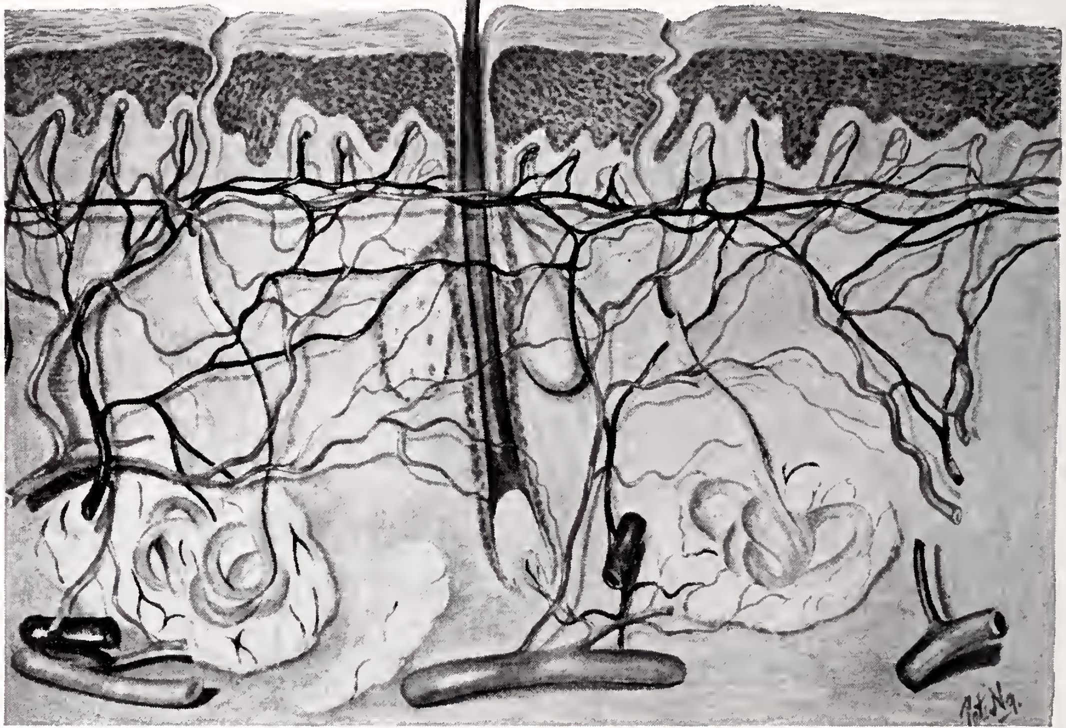

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No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B —bacitracin—neomycin) Antibiotic Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and rarely sensitizes.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

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Visitor Praises Restoration Of McDowell House

The following letter, from Miss Marguerite Marsh, Louisville, was addressed to Francis Massey, M.D., Lexington, chairman of the McDowell House Committee. The letter is sub-addressed to "Doctor McDowell."

Dear Doctor McDowell:

Yesterday I visited the McDowell House for the first time. I was so greatly impressed by the sensitivity and skill with which the restoration had been done that I wanted to express my appreciation of it to you.

It so happens that I spent my vacations for almost thirty years driving around the New England states. Being greatly interested in American history I visited every historical dwelling open to the public in all the Eastern states. Those which gave me the most insight into the lives of the original owners, and the times in which they lived, were those which had avoided the "Museum" atmosphere.

Yesterday, as I said to Mrs. Owens who was at the House, I had the feeling that Mrs. McDowell had just dusted and polished her home in readiness for expected guests and that she and Dr. McDowell had just stepped out for a moment. I can well imagine how much time, thought and skill went into achieving such a moving effect. So often restoration committees do not have the courage to refuse to accept gifts inappropriate for the times during which it was occupied by those we would remember. I could see that this hard task of refusal had been done at McDowell House with the needed firmness.

Miss Crawford's warm courtesy as hostess and Mrs. Owens' obvious deep interest added to the pleasure of our visit.

As a fellow-Kentuckian my thanks to you and all who made this gift to our state a living and moving memorial to a great physician and a brave woman.

Sincerely,
Marguerite Marsh

T.B. Association Has New Office

The dedication ceremonies of the Kentucky Tuberculosis Association's new office building at 4100 Churchman Avenue in Louisville were held June 25, according to an announcement recently released by Asa Barnes, M.D., president of the association. Doctor Barnes said the new office building "will add immeasurably to the efficiency of our organization and increase the services we can give the people of Kentucky." E. R. Gernert, M.D., Louisville, was a member of the building committee.

Robert D. Clary, M.D., has recently opened an office in Louisville for the practice of psychiatry. He is a 1953 graduate of the University of Louisville School of Medicine, and interned at St. Elizabeth's Hospital in Dayton, Ohio. From 1954-1960 Doctor Clary was in general practice in Guthrie and Evarts, Ky., following which he became a psychiatric resident in the U. of L. hospitals.

Ky. Commission on Aging Submits Report of Year

The Kentucky Commission on Aging submitted its report to Governor Bert Combs on June 4 for the period July 1, 1962-May 31, 1963, and outlined a number of its accomplishments including the publication of a directory containing many details on "Services Available to Kentucky Senior Citizens."

The Commission maintains a small library, publishes a quarterly newsletter, and has assisted with a number of meetings and workshops with programs devoted to subjects related to the aged.

A plan for employment and pre-retirement services was presented, and the Commission expressed its encouragement for churches to provide opportunities for Senior Citizens to participate fully in church life and to help the churches accept the responsibility toward the elderly who can no longer attend church.

The results of the Senior Citizens Day at the state fair last year were reported as were plans for a similar project this year. The Commission promoted a conference "Recreation for Senior Citizens" and has distributed 4,500 Senior Citizen Theatre Cards. Thursday, June 6, Senior House, Inc., a center that provides leisure, referral, and informational services to Senior Citizens, was opened in Louisville. A lack of housing for the aged was discussed and a resolution was passed endorsing a proposed Pilot Project to build low-rent houses for the needy elderly in 4 Kentucky areas.

KSMA members serving on the commission are J. Duffy Hancock, M.D., Louisville; Harold McPheeters, M.D., Commission of Mental Health; Earl P. Oliver, M.D., Scottsville; and Russell Teague, M.D., Commission of Health.

Dr. Whayne Attends Conference

Tom F. Whayne, M.D., vice-president of the U.K. Medical Center, participated July 17-19 in the Second National Conference for evaluating the Federal program of traineeship aid to professional nurses. Some 50 authorities on nursing, medicine, health, and education attended the conference in Washington, D.C.

The Professional Nurse Traineeship Program was established by Congress in 1956 to provide financial aid to nurses studying for teaching, administrative, or supervisory positions. The program applies to nurses undertaking full-time academic study and, since 1959, to nurses who require short-term courses to prepare for leadership positions. Since 1957, 185 nurses in Kentucky have benefited under the program.

Herbert N. Harkleroad, M.D., recently opened an office in Bowling Green, where he will limit his practice to internal medicine and gastroenterology. Doctor Harkleroad, a 1955 graduate of U. of L. School of Medicine, interned at Cook County Hospital in Chicago, following which he completed his residency at Henry Ford Hospital and at Cook County Hospital.

In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

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Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

In Kentucky

AUGUST

18 — Bluegrass Symposium, Kentucky Academy of General Practice, Phoenix Hotel, Lexington, Ky.

28-29 — Cave Area Seminar, Kentucky Academy of General Practice, Diamond Caverns Hotel, Park City, Ky.

SEPTEMBER

19 — University Surgery Day, University of Kentucky, Lexington, Ky.

23-26 — KSMA Annual Meeting, Phoenix Hotel, Lexington, Ky.

27 — Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

OCTOBER

4-5 — Sudden Cardiac Death Conference, University of Kentucky Medical Center, Lexington, Ky.

10 — Maysville Seminar, Kentucky Academy of General Practice, Mason City Health Building, Maysville, Ky.

17 — University Surgery Day, University of Kentucky, Lexington, Ky.

18-20 — Pediatrics Postgraduate Course, U. of L. School of Medicine, Children's Hospital, Louisville, Ky.

23 — Review of Current Problems in Obstetrical Anesthesia, U. of L. School of Medicine, Louisville General Hospital, Louisville, Ky.

24 — Rural Health Conference, Jenny Wiley State Park, Prestonsburg, Ky.

24-26 — Hematology Course, University of Kentucky, Lexington, Ky.

25 — Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

NOVEMBER

6 — Annual Fall Clinical Conference, Lexington Clinic, Lexington, Ky. Morning: Rheumatoid Arthritis; Afternoon: Specialized Diagnostic Techniques.

9 — Regional American College of Physicians, Holiday Inn, Lexington, Ky.

14-16 — Clinical Application of Newer Immunological Concepts, Department of Pediatrics, University of Kentucky, Lexington, Ky.

21 — University Surgery Day, University of Kentucky, Lexington, Ky.

29 — Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

DECEMBER

5-7 — The Family Physician's Role in the Pre and Post Operative Patient, Department of Surgery, University of Kentucky, Lexington, Ky.

19 — Annual Postgraduate Seminar, Norton Memorial Infirmary, Louisville, Ky.

19 — University Surgery Day, University of Kentucky, Lexington, Ky.

27 — Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

Surrounding States

SEPTEMBER

20-21 — National Rural Health Conference, Arlington Hotel, Hot Springs, Ark.

OCTOBER

5-10 — American Academy of Pediatrics, Palmer House, Chicago, Ill.

5-11 — Annual Otolaryngologic Assembly, University of Illinois College of Medicine and Illinois Eye and Ear Infirmary, Chicago, Ill.

24-26 — Annual Course in Postgraduate Gastroenterology, American College of Gastroenterology, Shoreham Hotel, Washington, D.C.

28-Nov. 1 — American College of Surgeons, Brooks Hall, San Francisco, Calif.

NOVEMBER

11-15 — American Public Health Association, Kansas City, Mo.

18-21 — Southern Medical Association, Municipal Auditorium, New Orleans, La.

DECEMBER

1-4 — American Medical Association (Clinical Meeting), Memorial Coliseum, Portland, Ore.

10-12 — Southern Surgical Association, Hot Springs, Va.

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Each capsule contains: Vitamin B_1 (Thiamine Mononitrate)...10 mg. / Vitamin B_2 (Riboflavin)...10 mg. / Niacinamide...100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B_6 (Pyridoxine HCl)...2 mg. / Vitamin B_{12} Crystalline...4 mcgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.

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(*Continued from Page 709*)

condition; perhaps this action of the drugs may be useful in these critically ill patients. The possible advantages of corticoid medication in this patient cannot be estimated, since she received only 200 mg. of Solu-cortef, an insignificantly small dosage.

Since electrolyte depletion results in shock, it is important to obtain relevant data on these patients regarding fluid and electrolyte balance. No such data were recorded in the case in question, and possible imbalances would necessarily have gone undetected.

It is known that many of these patients fail to respond to all therapeutic measures as long as infected material remains in the uterus. This patient expelled a piece of foul-smelling placental tissue nearly 24 hours after the onset of signs of septic shock. Perhaps the course might have been different if the uterus had been emptied when after 2 to 4 hours of intensive treatment no response had been noted.

Bridgehaven—Half-Way House

Louisville's Bridgehaven spans the gap between mental illness and a healthy state of mind. Bridgehaven is one of the first and oldest of a number of such half-way houses which have been established by communities all over the United States to provide a place where people well enough to leave a mental institution are helped to prepare to take their place again in the community. They are given business, social and recreational training which helps them adapt to ordinary living . . . and making a living.

Bridgehaven is well named. But bridges need support. As for your gift to human happiness, that is past computing! Bridgehaven, Inc., is located at 1423 South Fourth Street, Louisville 8, Kentucky.

News Items

Arthur B. Richards, M.D., has opened an office for general practice at the Louisa Medical Clinic, Louisa. Doctor Richards will practice in association with **George P. Carter, M.D., William J. McNabb, M.D.,** and **Forest F. Shely, M.D.** Doctor Richards is a 1954 graduate of Tufts University Medical School. He previously practiced in the state of Massachusetts.

Stephen B. Kelley, M.D., has announced the opening of his office in Somerset for the general practice of medicine. Doctor Kelley, who was graduated from Ohio State University Medical School in 1962, interned at Miami Valley Hospital in Dayton, Ohio, before coming to Somerset.

Stephen F. Collins, M.D., has entered into general practice at Shelbyville, according to information recently received. Doctor Collins, who was graduated in 1962 from the University of Louisville School of Medicine, completed his internship at James Walker Memorial Hospital in Wilmington, North Carolina.

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem.
KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.

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parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenol 0.25%; sodium carbonate as buffer.
Complete data with each 10cc vial. Therapy chart on request.

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Allergy Forum To Be Held

The annual meeting of the Midwest Allergy Forum will be held at the Sheraton-Cleveland Hotel in Cleveland, Ohio, Oct. 12-13. The scientific sessions will include panels on chronic pulmonary problems, cutaneous diseases, repository methods of therapy, and many other problems of clinical allergy. For further information write to: I. M. Hinnant, M.D., General Chairman, 10465 Carnegie Avenue, Cleveland 6, Ohio.

Ky. Heart Association Elects

New officers and board members were elected at the June 6 session of the Board of Directors of the Kentucky Heart Association, held during the Fourteenth Annual meeting of the association at the Kentucky Hotel in Louisville.

Among the new executives named were: William R. Bushong, M.D., Tompkinsville, president; George W. Pedigo, Jr., M.D., Louisville, first vice-president; and Louis J. Beto, M.D., Danville, board member. Doctors Bushong and Pedigo, Richard R Crutcher, M.D., Lexington, and Frank H. Moore, M.D., Bowling Green, were named to the executive committee.

Floridian Gets AMA Award

Lester R. Dragstedt, M.D., Gainesville, Fla., research professor of surgery at the University of Florida School of Medicine, received the AMA's Distinguished Service Award during the Presidential Inauguration Ceremonies at the Annual Meeting June 18 in Atlantic City.

Doctor Dragstedt, has achieved distinction in the fields of education, research, and practicing surgery. Among his many contributions to science was the first successful separation of Siamese twins in 1945. Doctor Dragstedt is a native of Montana and a 1921 graduate of Rush Medical College.

Internists To Meet In September

A regional meeting stressing the newer aspects in the treatment of diseases will be held by Kentucky internists at the Holiday Inn in Lexington on September 7. The session is one of the postgraduate education activities of the American College of Physicians.

Thomas M. Durant, M.D., Philadelphia, president-elect of the ACP, will participate in the scientific program and address the evening banquet.

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"THE PROBLEM DRINKER"

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And telephone bill...and utilities...and employee salaries...*if YOU are sick or injured?*

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(*Continued from Page 672*)

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News Items

Frances Brewer, M.D., Hyden general practitioner, has announced his plans for retirement effective in August, following which he will move to Connecticut. Doctor Brewer is a 1920 graduate of Columbia University College of Physicians and Surgeons.

William W. Wainer, M.D., has recently re-opened an office in Providence for the practice of general medicine after an absence for extra work. Doctor Wainer is a 1936 graduate of Boston University School of Medicine. A native of Boston, he previously practiced in Fort Lauderdale, Florida.

Charles D. Howard, M.D., has begun general practice at Springfield, according to a recent announcement. A 1961 graduate of the University of Louisville School of Medicine, Doctor Howard is a native of Washington County. He completed his internship at Columbus Medical Center in Columbus, Ohio, and served a general practice residency.

Robert L. Suttles, M.D., has entered general practice at Owingsville, Ky., it was announced recently. Doctor Suttles, a native of Carter County, is a 1962 graduate at the University of Louisville School of Medicine, and interned at St. Joseph Infirmary in Louisville.

F. J. Halcomb, M.D., and **Earl P. Oliver, M.D.,** Scottsville, are associated with others in the construction of a nursing home in Scottsville, according to a recent announcement. The completely modern nursing home is scheduled to open by October 1.

W. H. Wright, M.D., former health director in Robertson, Bracken, and Lewis Counties, has left Vanceburg to accept a neurosurgery residency at Los Angeles County General Hospital, Los Angeles, Calif.

Barney E. Elliott, Jr., M.D., general practitioner, has opened an office at Morganfield, it was announced recently. Doctor Elliott, a native of Owensboro, graduated from the University of Louisville School of Medicine in 1962. He interned at Mercy Hospital in Springfield, Ohio.

W. E. Kozee, M.D., who has been a general practitioner in Catlettsburg for the past four years, recently closed his office in that city to study psychiatry at Rollman Institute of Psychiatry, an affiliate of the University of Cincinnati. After completing his studies, Doctor Kozee plans to practice in Ashland.

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WASHINGTON NEWS DIGEST

WASHINGTON, D.C.—The Department of Health, Education and Welfare is well along in its investigation of krebiozen, the controversial product which has been distributed as an anti-cancer investigational drug.

HEW disclosed its progress in the investigation in answering a suit filed in federal district court by Dr. Stevan Durovic, a refugee Yugoslav physician who maintains he discovered krebiozen. The court denied Durovic's petition for a temporary injunction against the Food and Drug Administration which would have hampered the federal government's investigation of krebiozen.

HEW said it is trying to answer the basic question: Is krebiozen effective? To get the answer, HEW said, "it is necessary to know precisely what krebiozen is, how it is manufactured, and what controls are used to insure its safety, efficacy, sterility, purity, and identity. The results of tests on animals and full details of the case histories of tests on human patients must be known.

"It is the responsibility of the manufacturer to make this information available to FDA. The sponsors of krebiozen have been advised repeatedly since the filing of their first new drug application in 1954 that information submitted by them has not met the foregoing requirements."

FDA personnel began the government investigation last February by copying 508 case history records furnished by Durovic and for each of which it was claimed that krebiozen had been effective in some measure. The FDA then set out to obtain the full medical facts and records about each case. This entailed visits to patients, physicians, hospitals, laboratories, pathologists, surgeons, radiologists, and anyone else associated with the treatment of these patients.

"About half of the 508 cases copied by the Food and Drug Administration and NIH officials have already been thoroughly investigated by the FDA's field staff," the HEW said in a July 3 report. FDA expects to complete this phase of the investigation within a few weeks.

"As these completed cases are received by FDA in Washington, they are reviewed by medical officers of the Bureau of Medicine, FDA, and a summary made of each case together with the physicians' conclusions as to whether the claim of benefit is justified by objective evidence. The review of about 100 cases by these physicians has been completed to date.

"Physicians of the National Cancer Institute will make a second independent review of each case, consulting when necessary with outside experts in the particular fields of treatment involved to determine whether any claim of benefit is justified.

"These reviews will be the basis on which judgment will be made by scientists at the National Cancer Institute as to whether clinical testing by NCI is justified."

Durovic filed his suit for an injunction after FDA officials undertook to acquire information relating to the manufacture, packaging, processing, and distribution of krebiozen. In this inspectional phase of the investigation, the FDA seeks to determine the composition of the product, how it is made, the controls exercised in the manufacture to insure uniformity of composition, purity, sterility, potency, stability and safety, the labeling employed, the distribution of the product, and other matters bearing on the legality of distribution of the product under federal law.

The developers of krebiozen claim it is made from a yellowish-white powder extracted from the blood of a horse. This powder is dissolved in mineral oil and the combination is put into a glass ampule which holds one cubic centimeter.

Some of the powder substance was obtained from horses killed in Argentina and some of it from horses at Rockford, Ill. The blood of the horses killed at Rockford was used to prepare two batches of the powder in the Ken-L Ration Division of the Quaker Oats Co. in 1959 and 1960, the government brief said. The division makes dog food.

"The conditions of pre-treatment inspection of the horses, of injecting the animals, of selection of animals for bleeding, of bleeding, and of handling the blood and plasma met none of the basic requirements of current good manufacturing practice," the brief said.

* * * * * * * * *

The American Medical Association warned that research on new drugs could be seriously hampered by too exacting regulation and supervision by the federal government.

Dr. Hugh H. Hussey, director of the AMA's Division of Scientific Activities, told a Senate subcommittee that "medicine and the pharmaceutical industry have established an outstanding record, particularly over the last two decades, in the discovery, development and use of life-saving, health-saving, and pain relieving drugs."

"The benefit to our people from such discovery is so great in terms of reduced mortality and the increased control of numerous diseases that it is difficult to speculate what the state of our nation's health would be without them," he added.

Dr. Hussey said the AMA was well aware of the responsibilities of private industry in drug research, developing and marketing. But these activities, particularly research, could not be stereotyped, he said.

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References: 1. A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963. 2. Gruenberg, F.: Curr. Ther. Res. 2:1 (Jan.) 1960.

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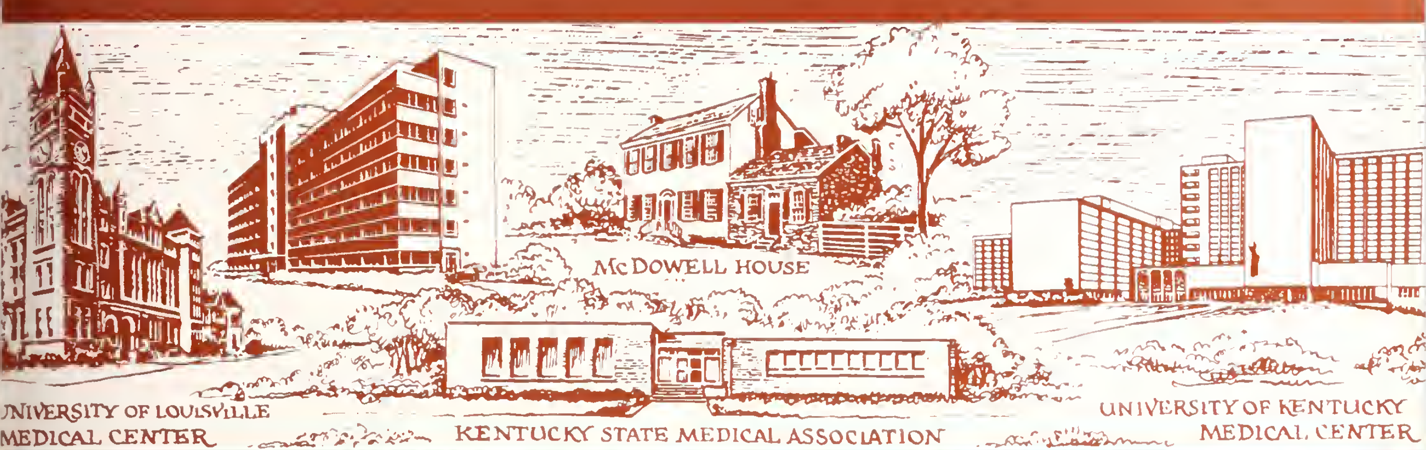

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MESSAGE FROM THE PRESIDENT

Annual Meeting

THIS year the Program Committee has arranged for one of the best scientific sessions we have ever had for our Annual Meeting in Lexington. Symposiums in depth have been so well received over the last few years that we are continuing them this year. Specialty meetings will be most interesting and instructive.

The House of Delegates will meet at 9:00 a.m. Monday, September 23, and the Reference Committees will give their serious and necessary consideration to problems that afternoon. This gives much more time to attend the scientific sessions, and to browse through the technical exhibits and reminisce with friends we see too seldom.

The ten five-year classes of U. of L. are planning their get-together meetings as usual. Over the years this custom has meant much to the KSMA and to the University of Louisville.

The Auxiliary is making extensive plans to see that our wives thoroughly enjoy their visit to Central Kentucky.

Arrangements have been carefully worked out, and whether the meeting is as good as we usually have depends on you, the members. An outstanding program has been prepared, but the real success depends on your attendence. Now, new highways all over Kentucky make traveling by car a real pleasure.

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*Blanchard, K., and Ford, R. A.: Clin. Med., 3:961, 1956.

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THE INSURANCE PAGE

The Insurance Review Board

THROUGH a recent action of the Board of Trustees of the Kentucky State Medical Association, an Insurance Review Board has been created. It is composed of seven members of the State Medical Association, who have been carefully selected by the Board of Trustees. One of these members shall serve as Chancellor of the Board.

By virtue of the responsibilities assigned to it, this newest committee may well prove to be one of the most important committees of the State Association.

Its purpose shall be twofold. First,—to protect prepayment pooled funds, such as those of insurance companies, or of Blue Cross and Blue Shield, against excessive and unwarranted claims against these funds, should such occur. Conversely, it shall investigate those instances, if any, in which physicians and their patients feel that their claims against prepayment organizations have not been given fair consideration.

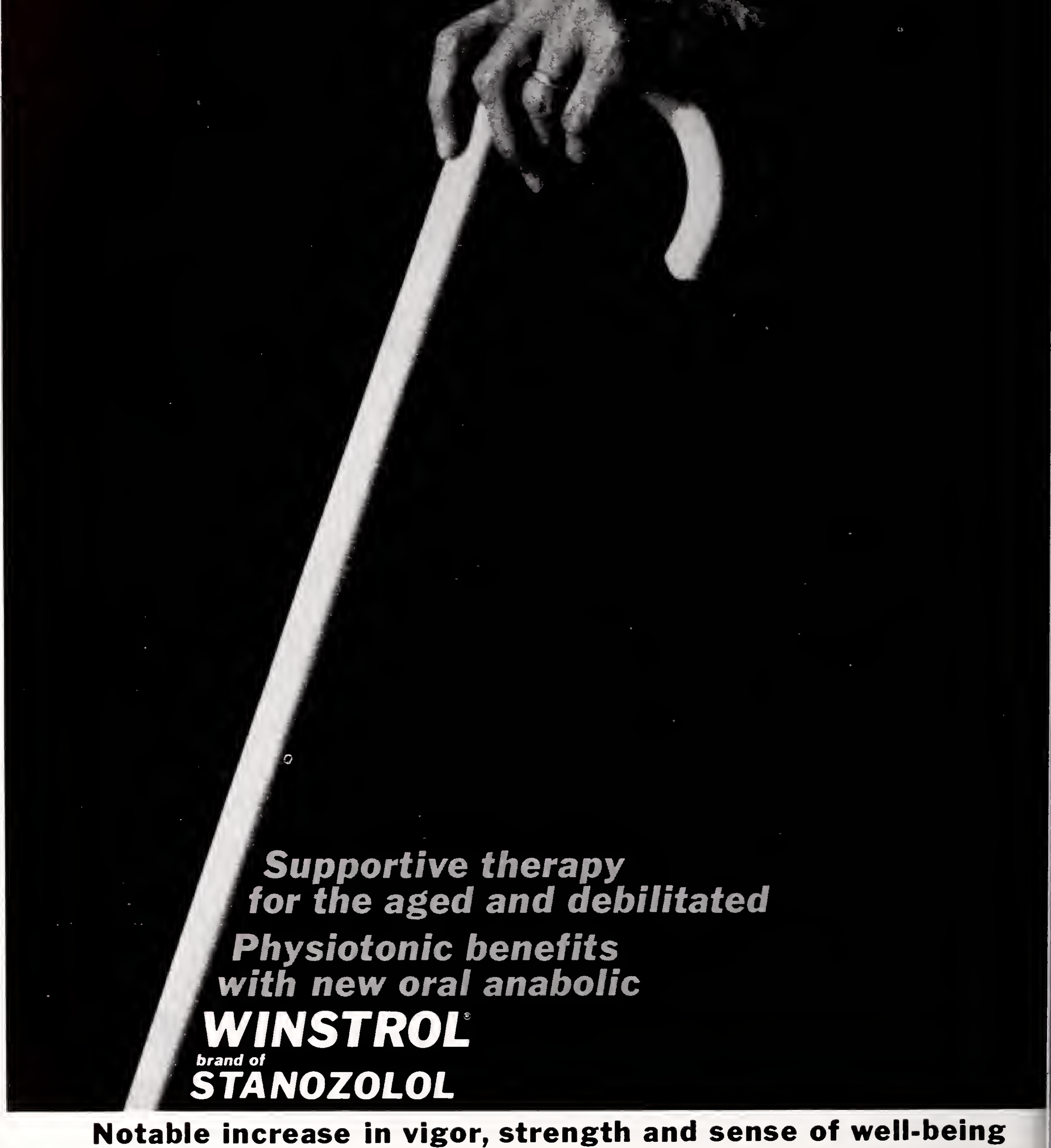
No problems of ajudication will be undertaken by the Board until, in its opinion, all possible efforts have been made by the parties concerned to reach satisfactory solutions to these problems.

In all probability, there will be an appreciable number of instances in which the parties concerned will be unable to agree on the correct answer to their differences of opinion as to what constitutes a fair fee, or proper utilization of services. In these cases, the committee will study all of the pertinent facts, and render an opinion as to the justness or, unjustness of the complaints. In reaching these conclusions the committee will have available the services of a Board of Consultants, composed of men whose experience and prestige will qualify each of them to speak in behalf of the medical specialty or prepayment organization which he represents.

The Insurance Review Board will have no disciplinary powers of its own, but it will have the responsibility of making recommendations to the Board of Trustees, should any disciplinary action be indicated. From the experiences of similar committees in other states, it is rarely necessary for a State Medical Society to discipline one of its members for flagrant and continued abuse of prepayment funds.

By the establishment of this board, the Kentucky State Medical Association has aligned itself with the majority of the other State Medical Associations, who, by creating similar committees, have expressed their belief that it is better for medicine to police its own ranks, than to run the risk that a small number of self-seeking individuals could undermine the confidence of the public in the voluntary prepayment system.

W. Vinson Pierce, M.D.



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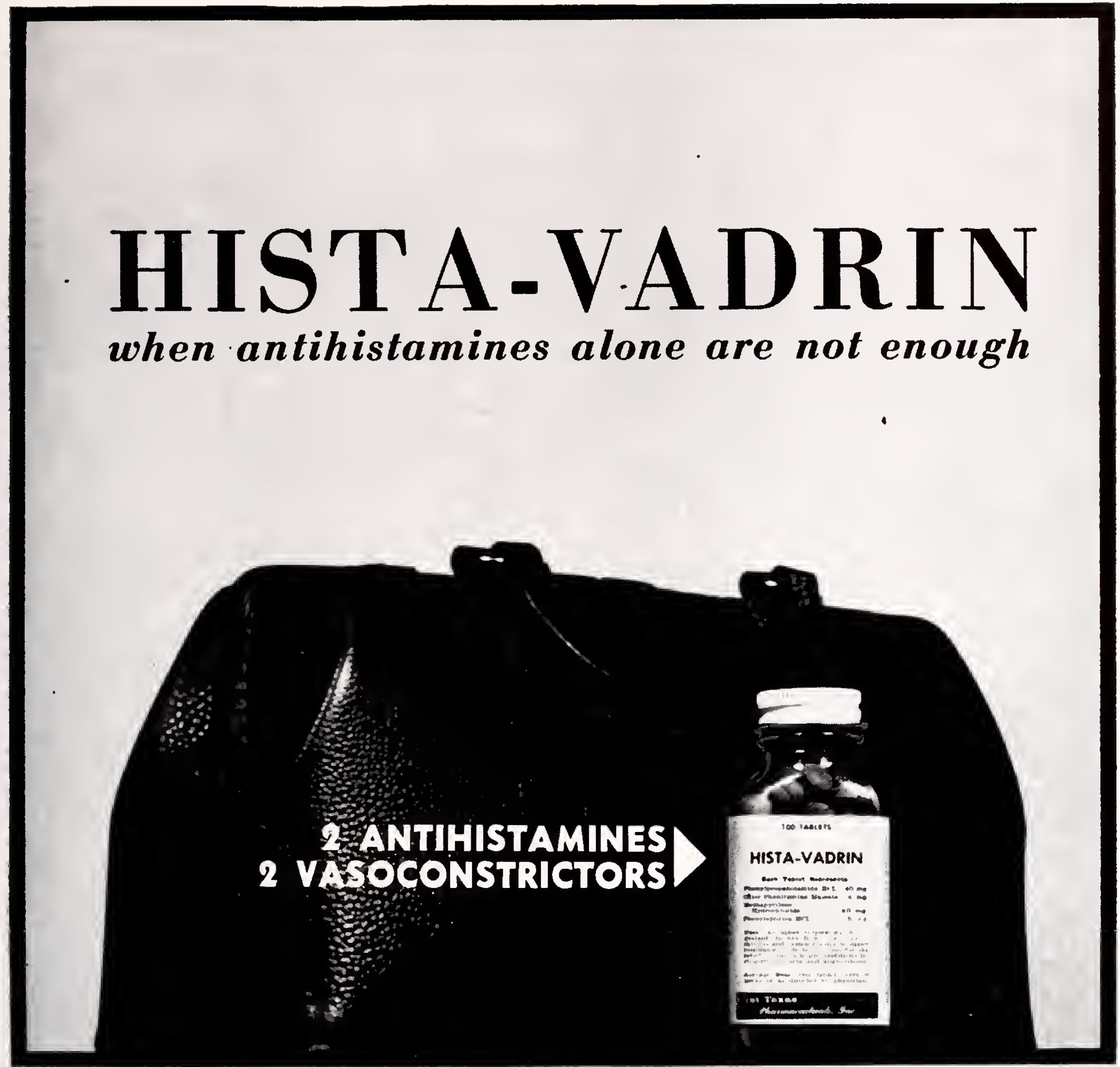

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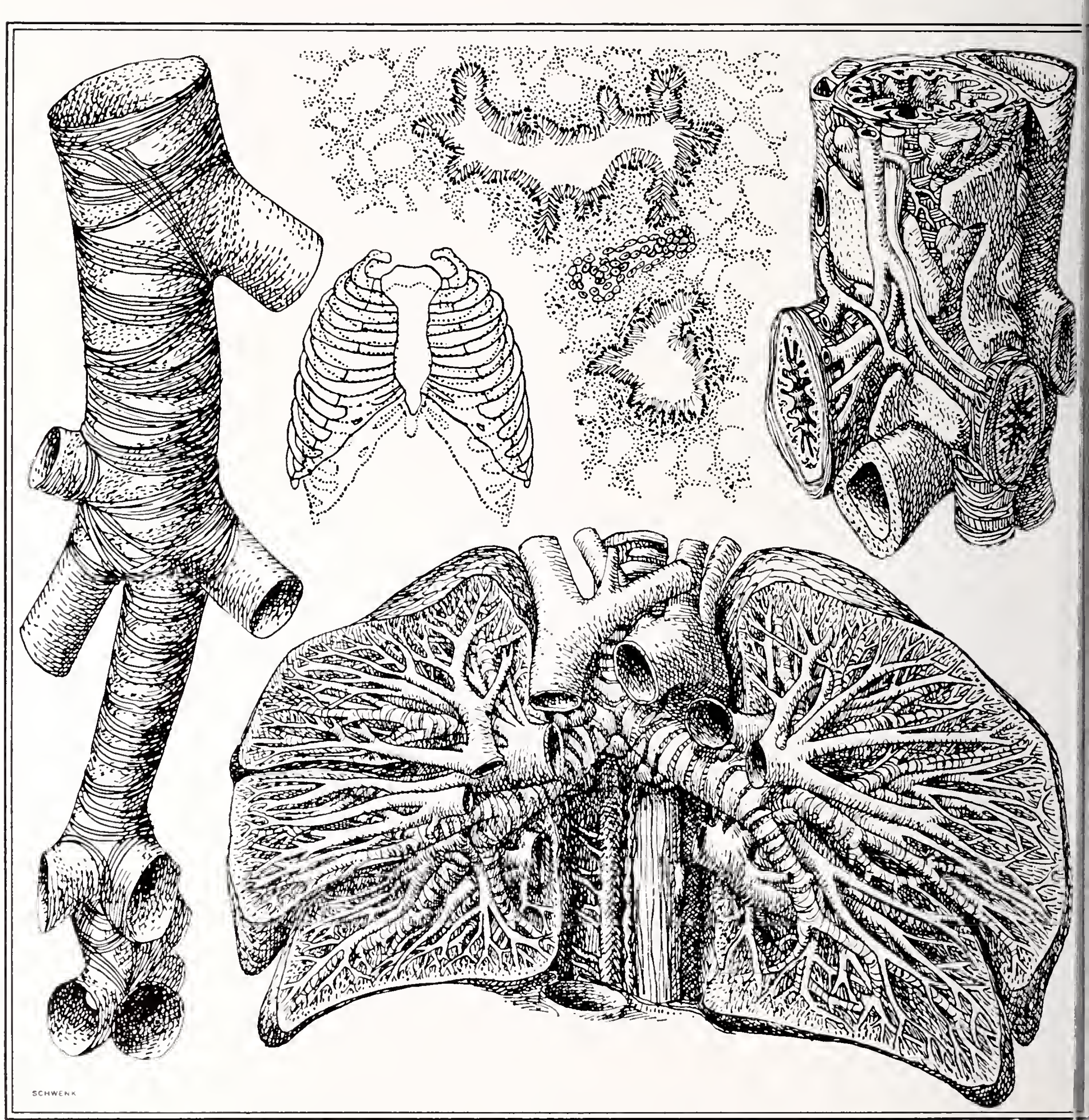
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Some Important Health Problems in Underdeveloped Countries†

JAMES A. HALSTED, M.D.*
Detroit, Mich.

The author discusses some of the basic economic and social factors in underdeveloped countries which bear on health problems. A new syndrome related to malnutrition, thought to be combined iron and zinc deficiency, is reported.

THE important health problems in the underdeveloped countries of the world have changed quite markedly during the past quarter century. Formerly infectious and parasitic diseases headed the list of ills which resisted solution. Although they still are the greatest killers, we now know how to control them. With technical aid and with economic and social progress, leading to improved sanitation, better nutrition and a higher level of education, it is only a matter of time when the enteric diseases of childhood, parasitic diseases, pneumonia, influenza, tuberculosis, and finally malaria, will be brought under good control, as they have been in the rich nations.

Diseases related to poverty and illiteracy, with resultant malnutrition are those which now defy solution and control. Here we cannot cure with antibiotics, D.D.T., and other specific drugs which have been so enormously successful against infections.

Disease Trends

I propose to indicate briefly some of the trends in the occurrence of certain diseases in the underdeveloped countries. Then, because we must know what an underdeveloped country is, it is important to mention some of the historic, economic and political factors involved and what role the medical profession may play in the efforts being made to help in the advancement of these countries. Finally, I wish to present an unusual and heretofore undescribed manifestation of iron deficiency anemia. Anemia is one of the most important causes of ill health as a nutritional disease in the underdeveloped countries.

Until recently, malaria killed more people than any other disease. As we know, the successes against it, largely influenced by efforts of the World Health Organization, have been phenomenal. Of one-and-one-third billion people living in malarious areas, not including Communist China, North Korea, and North Vietnam, 764 million, or 55%, have been protected by eradication programs. Those not yet protected are chiefly in Africa. Illness and chronic disability from malaria have dropped precipitously.

The number of reported cases of smallpox fell from 335,000 in 1950 to 60,000 in 1960, a reduction of 82%.

The average death rate from tuberculosis, in

†Presented at the First Scientific Session of the Kentucky State Medical Association Annual Meeting, September 18, 1962, in Louisville.

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countries with records available to W.H.O., fell by 65% between 1950 and 1958.

Trachoma, with a world-wide distribution, remains a great social problem because of the blindness it causes. Although control by antibiotics is feasible, health education, with insistence on elementary hygiene, yields the most encouraging results. So far, trachoma remains a most serious health problem.

Typhoid and dysenteries are still major health problems of several countries, yet they could be entirely controlled as they are in the advanced countries.

In the Middle East, infant mortality is very high—ten times that of western nations. Rheumatic fever, acute nephritis and other streptococcal diseases, are far more common than in the United States. Brucellosis, typhoid and echinococcus disease or hydatid cysts are especially frequent, as well as diarrheal diseases. Amebiasis, surprisingly, is not exceptionally frequent, but cirrhosis of the liver is one of the commonest diseases seen in the medical wards of the hospitals of the Middle East. The etiology of cirrhosis is not alcoholic, nor does severe protein malnutrition appear to be an important factor. A study of 40 cases conducted by my colleagues and myself indicated that the cirrhosis we encountered was of the post-necrotic type.[1] Although in China, primary cancer of the liver is common, engrafted on cirrhosis, this was not observed. Possibly this is related to the widespread occurrence of schistosomiasis as a basis of cirrhosis in the Far East but not in the Middle East.

Of interest in relation to the current emphasis on overnutrition, of which we are so concerned in this country, was the fact that coronary heart disease and cerebral accidents are rarely seen among the poor, although they are frequent among the rich. The same holds true for gallstones, obesity and, to a certain extent, diabetes.

In the Middle East, certain genetically determined diseases such as familial Mediterranean fever or periodic disease are quite common. Glucose-6-phosphate dehydrogenase defficiency occurs among 10% of Mediterranean people on the average, as well as Iranians, leading to acute hemolytic anemia after ingestion of certain drugs such as primaquine, and particularly from the fava bean which is widely eaten in the spring.

Malignant disease, with the exception of lymphoma (which is more common than in the United States), appeared to be somewhat less common than we see it here. However, lack of reliable statistics and records makes this more of an impression than an established fact.

The Roots of Ill Health

Thus we see that the pattern of disease is different in the underdeveloped countries. Let us examine briefly some of the economic, political and social backgrounds for the prevalence of poverty and malnutrition, for poor sanitation, and for lack of education which are at the root of ill health in the underdeveloped countries of the world. In other words, let us try to get a definition of "underdevelopment" so that we shall know about what we are talking.

Barbara Ward's recent book, "The Rich Nations and the Poor Nations,"[2] is a lucid analysis not only of underdevelopment but of crucial factors in the Cold War, and of the superficial attraction which Communism holds for recently emancipated but desperately poor countries. It is important for the medical profession to understand these factors since we also have a part to play in winning the Cold War. Medical education, public health, and medical aid are vital parts of the massive effort the rich nations of the West must make if we are to hold the poor nations of the world on our side. Let it be said here, however, that we shall keep them on our side only if we are truly interested in their welfare and understand the fact that our civilization cannot survive without a narrowing of the gap between the "have" and the "have not" nations. If our motivation is primarily *just* to keep them from joining the Communists, foreign aid will be largely wasted.

Professor P. M. S. Blackett told the British Association for the Advancement of Science recently that the rich countries must help the poor. The latter, he said, "have missed the bus not by default but by chance of history." He pointed out that the underdeveloped countries need three things urgently—money, people to teach them, and the will to get rid of bad vested interests and traditions.[2]

The age-long social pattern of feudalism prevails in many, if not most, of the underdeveloped countries. The few extremely rich people, mainly landlords with huge holdings, coupled with masses of desperately poor, is the common pattern. To these two classes of people

may often be added a third—nomadic tribes—found all through the Middle East. This group, obtaining their living mainly from their flocks, is usually better nourished and healthier than the poor villager who sells his few animals, chickens, eggs, etc., to buy clothes and household necessities. The villager's staple diet is grain. In Iran he may consume as much as two pounds of wheat each day—and little else.

As we know, there is great need for medical help along with other technical assistance and capital investment, if the West is to help and thus hold the underdeveloped areas. Medical education should be our prime effort. In this regard, imagination is essential. We must learn to adapt and to educate for local conditions. The people may wish an electron microscope, yearn for an isotope lab, hope to do open heart surgery—for these are great prestige symbols; but what is needed are much simpler fundamentals of medicine—how to use antibiotics, how to treat heart failure, basic surgical principles. Straight medical aid of the missionary type is, of course, helpful. Yet, in the long run, it does not develop the country. The people need education above all so that they can produce their own physicians and other health personnel.

Zinc Deficiency

In the process of providing teachers and medical education advisers for underdeveloped countries, extraordinary opportunities for clinical research will present themselves everywhere.

As an example, my colleagues and I found a group of patients, not previously described, with the following characteristics: Severe iron deficiency anemia, hypogonadism, dwarfism, hepatosplenomegaly, and an extreme degree of geophagia. All were males.

Study of these cases led to the hypothesis that zinc deficiency might coexist with iron deficiency and be responsible for the gonadal aplasia. Without doubt, it is a disease of malnutrition for we found it quickly reversible with proper treatment. Subsequent study of similar cases in Egypt provided strong evidence that zinc deficiency was responsible for the endocrine changes. Zinc deficiency has not previously been described in man.

Eleven cases were studied in Iran in 1958-1960.[4, 5] Since then additional cases have been studied in Egypt from the viewpoint of zinc metabolism.[6]

The cases were very similar in essential features, and the following case report is characteristic. However, Figure 1 illustrates the appearance of four of our patients.

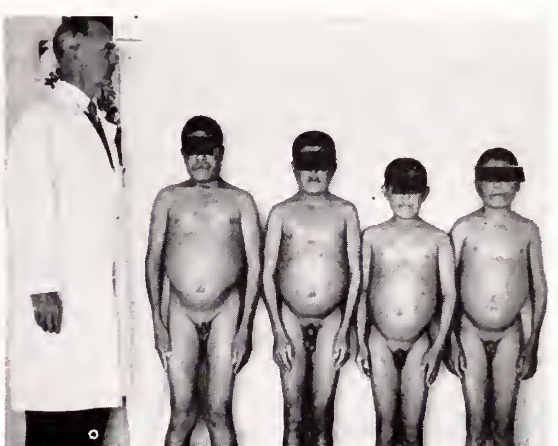

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Fig. 1 From left to right:

Case No.	Age	Height
5	21	4'11-1/2"
6	18	4'9"
3	18	4'6"
1	21	4'7"

Staff physician at left is 6 feet in height.

Case Report

H. Z., a 21-year-old male, complained of weakness of ten years' duration. For four years he had been unable to work, was pale, and had never developed sexually, nor had he grown normally.

During most of his life, the patient had been in the habit of eating large amounts of clay each day. His diet consisted chiefly of wheat bread with very little meat or animal protein and only small amounts of fruits and vegetables. Four siblings were living and well and three had died in early childhood. Another sibling, age 22, had the same clinical picture as the patient and also was a dirt eater, whereas none of the other siblings had this habit.

The physical examination revealed marked pallor in a male of 21 who appeared to be about 10 years of age. The heart was enlarged to the left with a rate of 100 and regular. There was a loud systolic murmur at the apex with some engorgement of the neck veins and slight edema of the ankles. The nails showed koilonychia.

The liver and spleen were markedly enlarged and there was abdominal distention without demonstrable ascites. The external genitalia were infantile and no prostatic tissue could be felt. There was no pubic, axillary or facial hair.

Laboratory Data

Hemoglobin, 3.5 gm. per cent, hematocrit, 17 per cent. The MCHC was 23 per cent. Several urine and stool examinations were unremarkable. The serum iron was 62 micrograms per cent and the total iron binding capacity was 495 micrograms per cent.

Liver function tests were all normal. These included serum bilirubin, thymol turbidity, cephalin flocculation, SGOT and SGPT. The prothrombin content was 100 per cent. The alkaline phosphatase was slightly elevated to 7.6 Bodansky units.

BUN, cholesterol, calcium, phosphorus, uric acid, and serological tests for syphilis were all negative, as well as a water test (Soffer) for adrenal function. The total plasma protein and chromatographic separation, were normal as well as a xylose absorption test. Gastric analysis showed achlorhydria on admission, and also six weeks after treatment.

Bone marrow biopsy revealed erythrocytic hyperplasia.

Liver biopsy revealed normal liver tissue. Testicular biopsy showed prepubertal testis.

The x-ray of the chest showed moderate cardiac enlargement with congestion of the hilar areas on admission. Two months later, when the hemoglobin had improved, the x-ray of the chest was normal. Complete x-ray of the gastrointestinal tract showed no abnormalities. X-rays of the long bones indicated the bone age to be less than 14 years.

Hospital Course

After initial studies, during which the patient received a normal hospital diet, oral iron therapy with ferrous sulphate was started. He had a prompt reticulocyte rise to 8 per cent ten days after beginning iron therapy. Eight weeks after treatment the hemoglobin had risen to 13.7 grams per cent and the hematocrit to 47 per cent. The liver and spleen had both receded in size.

The mild cardiac failure present on admission responded promptly to bed rest and therapy for anemia, without digitalis. After ten weeks of hospitalization, he had gained 16 pounds and was normal in strength, mental activity and behavior. Eight months later it was revealed that he had been eating an adequate diet consisting of meat, bread, rice, and fruit daily. He now had erections and questionable ejaculation. The liver and spleen were barely palpable. Pubic hair was present. The hematocrit was 49 per cent and alkaline phosphatase 15 Bodansky units.

Discussion

Although this patient, as well as the others in the study, had a markedly deficient animal protein diet, none of the features of Kwashiorkor were present. The serum proteins and liver function tests were normal. There was little fat in the liver on biopsy, and there was no ascites. Neither were the skin and hair changes which are characteristic of Kwashiorkor present in these patients.

No explanation for the hepatosplenomegaly could be obtained other than the fact that this is sometimes seen in profound anemia without adequate explanation. In none of the patients was there evidence of cirrhosis or fatty infiltration of significant degree.

The pathogenesis of the severe anemia which was present in all of the cases may be explained as follows: All of the findings as well as the prompt response to iron therapy indicated that this was a severe iron deficiency anemia. This is extremely rare in Western countries without blood loss which did not exist in any of these patients. Hookworm infestation is not seen in the part of Iran where these patients were studied and all stool examinations were negative for occult blood and for parasites. Some iron loss, however, may occur through excessive sweating and skin desquamation from sunburn in a hot climate, and this may have played a part in the iron deficiency.

There was no evidence of intestinal malabsorption. However, although wheat contains a considerable amount of iron, namely 3.4 mg/100gm., much of this is probably unavailable for absorption because of the very high phosphate content of wheat. Furthermore, the clay consumed in such large amounts by all of these patients may have interfered with iron absorption in an unexplained way, possibly

from chelating properties. However, this can only be speculative.

Finally a partial vitamin C deficiency may have existed because the dietary histories revealed low intake of foods containing vitamin C, which is important in promoting iron absorption by virtue of its properties as a reducing substance to convert ferric to ferrous iron.

Although laboratory facilities were not adequate for extensive endocrine studies, there was no clinical evidence for pan-hypopituitarism, hypothyroidism or hypoadrenalism. Hypogonadism may have been either primary or secondary to lack of pituitary gonadotrophic hormone. The pituitary gland is known to be unusually susceptible to malnutrition especially in relation to the gonadotrophic and growth hormones. Thus it is likely that both hypogonadism and dwarfism in these patients were caused by anterior pituitary failure related to malnutrition. Of considerable interest is the fact that in those patients who could be followed for several months, pubic hair appeared with increase in size of penis and testes and marked increase in weight and height.

The serum alkaline phosphatase was distinctly elevated in all cases after they received a good diet in the hospital. In some patients it rose very markedly, as high as 32 Bodansky units, four to six months after admission.

Zinc metabolism, studied in normal subjects and patients with this syndrome by Prasad in Cairo,[6] showed a consistently low plasma zinc in all the patients, as well as a decrease in the excretion of radioactive zinc in the urine and stool, indicating body conservation in the zinc deficient state. The zinc content of hair was also found to be low.

The zinc content of almost all foodstuffs is similar to that of their iron content. The same factors favoring malabsorption of iron in these patients might also interfere with absorption of other heavy metals such as zinc due to the formation of insoluble complexes with phosphate. Testicular atrophy occurs in experimental zinc deficiency in rats and there is lack of growth and retardation of skeletal maturation in these animals as well as in the mouse, and hog put on zinc deficient diets. Finally changes in the alkaline phosphatase, which is a zinc-containing enzyme, have also been observed in hogs with zinc deficiency. Increasing activity of this enzyme has been noted when these animals received increased amounts of dietary zinc.

The entire clinical picture, therefore, appears to be one which can be explained on the basis of a combined iron and zinc deficiency. It is of interest that all of the patients were males. The high concentration of zinc in the male reproductive tract, but not in the female genital tract, has been noted. This may explain the fact that none of the patients were females. (However, geophagia and anemia alone, but without the endocrine changes, are often seen in females).

As a result of our observations, it is believed that growth retardation and gonadal hypofunction may be related to zinc deficiency in some manner. This is an interesting example of a hitherto undocumented syndrome of malnutrition and is presented not only for this fact alone but also because it serves to illustrate the great opportunity for clinical investigation which exists in the underdeveloped countries. There diseases are seen in a florid state similar to what existed in the advanced countries a century or more ago. Now, however, there is a vast increment of knowledge in medical science, and the tools to discover causes and mechanisms.

Summary

A broad summary of the general state of medical problems in underdeveloped parts of the world has been presented.

Some historical, social, economic and political factors have been mentioned as features related to the state of what is generally called "underdevelopment."

A syndrome of iron deficiency, hepatosplenomegaly, hypogonadism, dwarfism and geophagia is presented. Evidence is offered which suggests that the endocrine changes in this syndrome are caused by zinc deficiency.

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Role of the New Outpatient Tuberculosis Clinics in Kentucky†

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Some of the problems of tuberculosis case finding and control in the eastern section of Kentucky are discussed. The purpose and mode of functioning of the mobile unit clinic is presented.

THIS IS A preliminary report based on the experience of the first twelve clinics held between July 5, 1962, and November 1, 1962.

I gratefully acknowledge the contribution of Mr. Thomas Layton, Executive Director of the State Tuberculosis Hospital Commission, and M. Stuart Lauder, M.D., Director of the Division of Tuberculosis Control, State Department of Health, who originally conceived of these mobile clinics. It was through their enthusiasm, faith, and untiring efforts that funds were obtainable to activate these units.

Physical Equipment

The mobile units are composed of all the equipment necessary to perform complete diagnostic and therapeutic functions. They consist of a station wagon loaded with supplies. The equipment consists of the records of the patients to be seen, the ordinary materials contained in a physician's bag, the drugs ordinarily used in the management of tuberculosis, tuberculin and histoplasmin skin testing materials and sputum containers for serological testing when indicated. These are packed into luggage-like containers that were made for the purpose. Portable dictating machines, typewriters, and office supplies are also included, as well as x-ray films which are supplied by the mobile unit.

Personnel and Operation

The workers consist of a medical doctor, social service worker, registered nurse, licensed practical nurse, secretaries, laboratory technician and an x-ray technician. The latter is supplied by the Department of Health.

The social service workers attached to the mobile unit, several weeks before a scheduled clinic, make a list of the patients we want to see. This list is then forwarded to the local health department for correction, addition of cases known to them, and deletion of cases who have moved away, died, or entered other hospitals. Invitations are then sent to the patients to attend the clinic on the date it is to be held. The corrected list is then returned to the hospital. The charts and x-rays are pulled and the station wagon packed. The team meets at the hospital the morning the clinic is scheduled, and leaves in time for the clinic to start functioning at 9:00 A.M.

X-rays are taken by a stationary machine if one is available. If not, the mobile x-ray unit drives in front of one of the entrances to the building, and the patients are x-rayed in that unit. For our purposes, only 14 x 17 inch films are taken.

At the completion of the clinic all the material is repacked, including the exposed but undeveloped x-ray films. The following day the charts are processed and the x-rays are developed and sorted. These are then given to the attending physician who dictates a summary of the case, including the x-ray reading and recommendations. Copies are sent to the state health department, the local health department and the family physician, and one is kept in the patient's chart.

When a patient is seen his history is taken and he is examined. His previous x-rays are

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inspected. Recommendations are then made based on the knowledge at hand at that time. After reading the new x-ray, further recommendations or suggestions may be made which can be carried out through correspondence with the personal physician or the health department.

It is a rule that every patient who comes through these clinics shall have a skin test of P.P.D., intermediate strength, unless a positive P.P.D. has previously been obtained. The patients who are skin tested are given a self-addressed, stamped card with a proper form on the opposite side and instructed to consult their physician or the health nurse in two or three days for reading. The reader notes the number of millimeters of induration or "negative," as the case may be, and mails it to the hospital where it is incorporated into the patient's record.

When the report is complete a recommendation is made as to when the patient should return to the clinic for follow-up. A record is kept of these oppointments so that patients may be notified of their next clinic date.

The Health Department's Role

These clinics are all held in the local health departments of the counties involved. They are held with the consent of and wish of the local health department, from whom, I am happy to state, full cooperation has been obtained. They are always held on a day when no other clinics are scheduled in that health department, so that the entire facility is available for the use of the mobile tuberculosis clinic.

So far we have been holding clinics three times a month in six counties, alternating every month, so that six counties have until now been served. They are Pike, Floyd, Martin, Wolfe, Rowan and Lewis. They represent those counties which are most distant from the hospital and which apparently have the greatest problem.

Plans for the new year have already been formulated. The clinics seem so successful that we plan holding two each week, four times a month, which will enable us to serve every county in this hospital district, except the county of Boyd in which the hospital is located. Our plans include serving Pike and Floyd County every month because of the tremendous case loads which we have seen in those counties and the great distances involved.

Kentucky still ranks among the highest in the incidence of tuberculosis in the United States. The problem in Eastern Kentucky is further increased by factors which we shall soon discuss. I am informed by the Kentucky Tuberculosis Association that the incidence of tuberculosis reported in this fiscal year up to date seems to be on the increase when compared with recent years.

The Local Tuberculosis Problem

Hospital District Number Four which we serve is composed of 319,000 people of which 255,000 are rural and 64,000 urban. The problem locally is predominantly one of rural population rather than urban population. This contrasts with the findings of most other areas where tuberculosis is becoming more and more a disease of cities and less and less one of rural dwellers.

The character of the people we in the main serve presents a problem somewhat peculiar in itself. The level of their intellectual accomplishment is very low, and the rate of illiteracy is extremely high, less than ten per cent of our hospital admissions being high school graduates.

They are extremely depressed economically, most of the people in the large counties depending on coal mining for their existence. Many of them live in the poorest of abodes under crowded conditions, and subsist on an inadequate diet, which contributes further to the spread of disease. Also, the families are frequently large, six, seven, eight or more children being not uncommon.

As is to be expected in people existing under such conditions, they are quite emotionally unstable and have an almost superstitious attachment to their homes and families. As a consquence, they are resistant to any change and make poor adjustments in the hospital. As a matter of fact, in a recent study I did of all the patients admitted from one of our counties in the last fiscal year, 70% left A.M.A., most of them for no other reason than that they wanted to return to their homes and families.

In spite of repeated attempts to indoctrinate these people, they are unwilling or unable to understand the nature or seriousness of their disease. Many refuse to admit that tuberculosis is the cause of their illness, particularly after the first month or two of treatment when they are feeling better. Many more do not believe in the infectious hazards of exposing their families. They are unable to realize the potential for

harm of the disease with which they are afflicted. I suspect that they have been living in an environment of tuberculosis so long that they accept it as a part and parcel of the risk of living (just as we accept the automobile).

The character of the local disease itself has not followed the trend seen in most of the country in that it is still a disease of young adults. The average age of the hospital population is in the low forties, whereas throughout the rest of the country it is becoming a disease of advancing age.

The disease is usually a rapidly advancing exudative type, very similar to that seen many years ago, and somewhat similar to that seen in the Negro or Indian.

Complications are frequent. A high percentage of the patients have pneumoconiosis, chronic bronchitis, emphysema, bronchiectasis and other respiratory difficulties, even at a rather youthful age, and many, of course, suffer from dietary deficiencies of a mixed type. The incidence of diabetes and peptic ulcer also appears high.

Because of the high A.M.A. rate there is an extremely high rate of resistance to drugs in the old cases and, as is to be expected, a high rate of primary resistance.

In many of the counties the cooperation of the local judges is difficult to obtain, and as a consequence highly infectious cases with far advanced disease are not incarcerated so that their infectiousness might be controlled.

And, last but not least, is the matter of terrain which is hilly and/or mountainous. During snows or ice or floods many are unable to communicate with the outside world. Transportation may be difficult except on the main highways. Many of the people have no cars or may have no money for gasoline even if a car is available. Some of the patients must walk many miles from the bus lines to their homes.

Eligibility Requirements

The purposes of these clinics are limited to the field of public health and are established to attempt to find and control tuberculosis. We are leaning over backwards in an attempt to avoid conflict with the private practice of medicine. Under no conditions will patients be accepted in these clinics for routine examinations or routine screening. Routine examinations should be conducted by the private physician. Routine screening programs for tuberculosis, such as is necessary for teachers, food handlers and groups of such nature, are to be conducted by the mobile x-ray unit.

The people we are interested in are known cases of tuberculosis, active or inactive, suspects, and all contacts of active cases. We are following up cases of suspicious x-rays from the mobile x-ray unit and expect to perform routine skin-testing programs, such as schools, if such is the desire of the local health departments, or at least to aid those officials in the performance of such surveys.

Private patients will be seen only upon receipt of a written note from the family physician.

The Place of Antituberculous Drugs in this Program

Only antituberculous drugs will be dispensed by this unit. All other medications must be obtained from some other source.

Necessary drugs will be dispensed free of charge after ascertaining the individual is not capable of paying. If they are capable of paying, recommendations will be forwarded to the private physician, who can dispense the prescriptions recommended if he deems it advisable.

A tremendous step forward has recently been taken in the handling of drugs in that the Tuberculosis Commission, upon the recommendation of the Executive Director, liberalized its policy so that we may now dispense drugs to all people with active or inactive or potentially active tuberculosis if deemed advisable by the clinic physician. Previously we were not allowed to dispense drugs to patients who went A.M.A., and as a consequence, many of those people who would sincerely make an effort to control their infectiousness were not able to do so. That ruling has now been changed, so that we may now dispense drugs in keeping with the recommendation of the Committee on Therapy of the American Thoracic Society.

Results

In the first twelve clinics held in the six counties previously enumerated, I would estimate that well over twenty-five per cent of the people consulted were patients who had previously lapsed follow-up. This is a rather significant figure. Many of those were found to be recent converters or reactivaters.

Six hundred ninety-eight clinic visits were

made in twelve clinics, or an average of fifty-eight patients seen in each clinic.

Fifty-seven patients were seen twice, making a total of 641 patients that were seen in 698 visits.

Two-hundred ninety-one were new patients, never seen either in the hospital or in the Ashland clinic in the past. Of those 291 new patients, 57 were referred by private physicians, 29 were referred by the health departments, seven were referred by the mobile x-ray unit, 185 were contacts of active disease, thirteen were drop-ins or designated as "'source unknown."

Two hundred eighty-six P.P.D.s were done; 70 were reported as positive, 139 were reported as negative, eight reported as doubtful, and 69 were not reported.

Medication was dispensed to 93 people, either therapeutically or prophylactically.

Six hundred thirty-seven x-rays were taken.

In attempting to classify a diagnosis, I was purposely ultraconservative and, if there was any doubt of the activity of disease, I purposely classified them as suspects until that time when activity could be determined, when reclassification will take place. As a consequence, I dare say that there are a fair number of cases of active disease among those labeled as suspects.

Recent converters were also grouped with suspects unless their x-rays revealed unequivocal evidence of active disease.

There were 34 cases of active pulmonary tuberculosis found in those attending these 12 clinics. Eleven were new cases not previously seen or diagnosed. Seven were reactivated old cases, i.e., individuals who had been previously treated and rendered inactive and so classified, whose disease has now been recognized as having reactivated. Sixteen cases were classified as old active. These were cases who left the hospital against medical advice or who were discharged with maximum hospital benefit or who had been diagnosed as active tuberculosis previously and never accepted hospitalization, etc. In other words, they are continuously active cases.

Two hundred nine were diagnosed as having tuberculosis in an inactive or quiescent phase. Three hundred ten were classified as no disease; 34 were classified as having nontuberculous disease. There were 46 listed among the suspects and eight who had not obtained an x-ray and on whom no diagnosis had been made, making a total of 641 in all.

I suspect that the reported 34 cases of active disease is very conservative and feel sure that many more cases subsequently will be classified as active when further studies are available on those individuals.

Summary

This is a preliminary report on "The Role of the New Outpatient Tuberculosis Clinics in Kentucky" in which I have attempted to outline the functioning of these units and define the need for such clinics.

Preliminary results are very encouraging. The attendance has been greater than anticipated and an average of 58 patients have been seen in each clinic held in this district.

Thirty-four patients have been found to have active disease. Approximately thirty per cent, or eleven of those patients, had not been seen before and were classified as original diagnosis cases. The rest were reactivations of previously arrested disease or cases of continuously active disease who had never been rendered inactive.

Undoubtedly many of those now labeled suspects eventually will be proved to have active disease as well.

This represents almost three active cases of pulmonary tuberculosis found at each clinic, and represents approximately one patient in 20 seen in the clinics with active disease.

A classification is being devised for these patients so that in the future available data can be assembled with relative ease.

The problems of these units were many, and varied from locale to locale, and we anticipate that others will arise. I believe these clinics show great promise as an adjunct to the already previously standardized and accepted methods of diagnosis and control of tuberculosis.

Familial Occurrence of the Dubin-Johnson Syndrome†

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Three brothers of a case previously reported in this Journal by Lloyd Yopp, M.D.,[4] also have the anomaly. As in other series, the majority have been explored with the mistaken diagnosis of surgical jaundice.

THERE are several types of metabolic defects in bilirubin metabolism which have for years been grouped as idiopathic or constitutional hepatic insufficiency. Recently they have been classified on the basis of conjugation of bilirubin.

Bilirubin results from the breakdown of hemoglobin by oxidation, removal of iron, and two hydrogenation steps (Fig. 1). Indirect bilirubin is still bound to protein. In normal hepatic

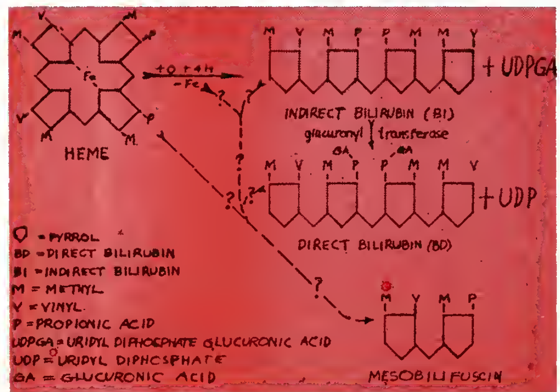

Figure 1. Lipofuscins as degradation products of bilirubin.

cells it is acted on by an enzyme glucuronyl transferase and conjugated by esterification of its propionic acid groups to two molecules of glucuronic acid. The glucuronic acid is supplied by a compound uridine diphosphate glucuronic acid. This is the same type of conjugation by which the liver excretes phenols and numerous other substances. When bilirubin is conjugated with glucuronic acid it reacts promptly with diazotized sulfanilic acid of the van den Bergh test and is said to be direct bilirubin whereas the unconjugated bilirubin is indirect bilirubin.

Classification of Defective Bilirubin Metabolism

Arias[1] classified these defects as follows:

I. *Unconjugated hyperbilirubinemia (non-hemolytic acholuric jaundice)*
   - A. Newborns and Infants
     1. Physiologic jaundice of the newborn—Due to delayed development of transferase.
     2. Jaundice of the premature infant—Same delay.
     3. Transient familial neonatal hyperbilirubinemia—Due to delayed development of transferase plus inhibitory substance.
     4. Crigler-Najjar Syndrome — Glucuronyl transferase deficiency — Familial.
   - B. Adolescents and Adults (constitutional hepatic dysfunction—Gilbert's disease)
     1. Bilirubin above 5 mg.%—Glucuronyl transferase deficiency—Familial.
     2. Bilirubin below 5 mg.%—Heterogeneous group, mechanism unexplained.
   - C. Homozygous Gunn Rat — Glucuronyl transferase deficiency.

II. *Unconjugated and conjugated hyperbilirubinemia*
   - A. Dubin - Johnson Syndrome (familial non-hemolytic icterus with conjugated bilirubinemia and abnormal liver pigment)—Due to hepatic excretory defect.
   - B. Familial non-hemolytic icterus with conjugated bilirubinemia and no abnormal liver pigment—Due to hepatic excretory defect.

Arias[1] believes that both types of familial

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non-hemolytic icterus (with and without pigmentation) are variants of the same disease, since he has seen both types in each of two families.

The Dubin-Johnson Syndrome

Dubin and Johnson[2] in 1954, and independently, Sprinz and Nelson[3] in the same year, reported liver biopsy specimens with large amounts of brown pigment in hepatic cells around the central veins. Clinical features of 12 such cases were described by Dubin and Johnson. Sprinz and Nelson described four such cases. The pigment in the hepatic cells is thought to be a lipofuscin.[3]

In the reported cases the gross appearance of the liver has varied from near normal color to black-brown. The surface ranges from smooth to a tendency toward nodularity and thickened capsule. Microscopically there is a coarsely granular brown pigment in the parenchymal cells. The pigment is most prominent around the central vein, involving the inner half of each lobule. The liver cells are otherwise normal. There is no necrosis, no fatty infiltration, and no evidence of obstruction of bile canaliculi. Periportal spaces show no increased fibrosis and no inflammatory infiltration.

Current Concepts

Yopp's[4] paper reviews current concepts of the disease as defective excretion rather than defective conjugation. But since excretion, transport, and metabolism are dependent on enzymatic activity, the concept of excretory defect remains consistent with genetic influence ("one gene, one enzyme") and familial occurrence. Fuscins (Fig. 1) are dipyrrrolic degradation products of hemoglobin breakdown. It is not known with certainty whether bilirubin normally breaks down into fuscins which in this disease cannot be excreted by liver cells and therefore accumulate in the cells with damming up of unmetabolized bilirubin; or whether bilirubin itself cannot be excreted, is dammed up with its precursors which are changed to fuscins by the spillway of an alternate metabolic pathway. Evidence[5, 6] favors the latter alternative. Either explanation would be compatible with the observations in the disease and with classical theories of genetic metabolic defects.[7] Several papers[5, 8, 9, 10, 11] since 1956 have described the familial occurrence of this disease.

Clinical and Laboratory features

In 1958 Dubin[12] reviewed the clinical findings of 50 collected cases which showed the syndrome of direct bilirubinemia with pigment deposition in the liver. He collected the figures which are shown below. (The denominator of the fraction designates the number of the 50 cases in which the particular parameter was searched for, the numerator the number in which it was observed).

Age: less than one year to 76 years

Sex: 38/50 male, 9/50 female, 3/50 not specified (many data from armed forces and VA hospitals may weight this.)

Symptoms: 10/44 asymptomatic; 34/44 right upper quadrant pain; 22/44 weakness, fatiguability; 11/44 anorexia; 15/44 nausea and vomiting; 6/44 diarrhea.

Signs: 22/42 hepatomegaly; 15/42 hepatic tenderness; 20/42 dark urine; 5/42 pale stools.

Laboratory: 45/50 normal hematology; 24/24 normal reticulocyte count; 34/34 normal osmotic fragility of erythrocytes; 17/17 negative Coombs test; all examined showed normal bleeding, clotting and prothrombin times; 26/35 bile in urine; 21/35 increased urine urobilinogen; 46/46 increased serum bilirubin at some time, ranging from 2 - 20 mg.%, average 60% direct; 12/46 serum bilirubin normal at some time; 13/37 transient 3+ or 4+ cephalin flocculation; 0/37 persistent 3+ or 4+ cephalin flocculation; 23/30 BSP retention of 10-20%; 13/31 thymol turbidity above 4 units; 4/34 alkaline phosphatase slightly elevated; all examined—normal total serum proteins, A:G ratio, electrophoresis and cholesterol; 31/37 non-visualizing cholecystograms.

Abdominal exploration was done on 30/50. 25/30 showed no gallstones; 5/30 showed gallstones; 5/5 gallstones caused no obstruction.

Except for possible complications in survival of offspring of afflicted women (no data on offspring of afflicted fathers are given) the disease appears to run a benign course throughout a normal life span without evidence of progressive hepatic damage. Dubin's[12] figures showed the following statistics:

Onset—24/50 insidious; 9/50 acute, resembling hepatitis; 10/50 after stress or infections, 7/50 not specified.

Females—7/9 became pregnant once or more.

In 6/7 the pregnancies aggravated or first precipitated the disease.

4/7 pregnant women had normal children.

Of 12 pregnancies in the other

3 women, 2 resulted in normal children; 1 in neonatal death; 8 in spontaneous abortion; and 1 in a monster.

There is no known treatment for the disorder. A good family history, or perhaps better, family observation, plus a liver biopsy of patients with familial direct hyperbilirubinemia should save some siblings from unnecessary cholecystectomies and iatrogenic invalidism from faulty diagnosis of hepatitis. The condition is relatively benign.

Case Reports

We report here three brothers of Dr. Yopp's[4] case. Three of the four brothers had gallbladder explorations and liver biopsies by three different physicians.

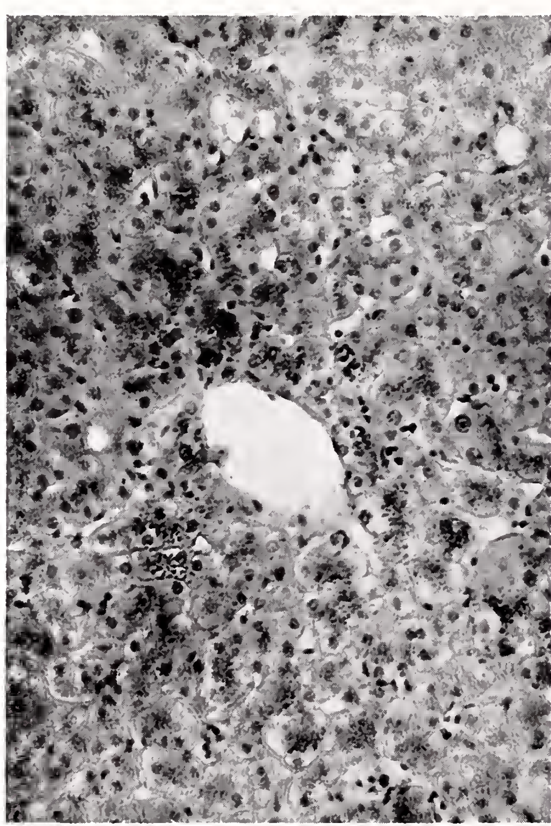

Figure 2. Morris Y. Liver Biopsy December 2, 1960, H & E Stain. Granular pigment in liver cells around central veins.

Case 1. Morris Y, born in 1909, had a disc operation in 1956. Postoperatively one of us (WPW) observed him to have transient jaundice and mild diabetes, and elicited a history of his having passed dark urine off and on for as long as he could recall. In December 1960 after receiving no relief of his diabetic neuropathy over a three month period and no treatment of his direct bilirubinemia by another (MCD, who knew that the Y brothers turned yellow frequently) he was seen at St. Joseph Hospital by WPW who had seen him in 1956. With diabetes and direct bilirubinemia a suspicion of carcinoma of the pancreas was raised. Exploration revealed a normal gallbladder without stones. Biopsy of a dark-stained liver revealed brown pigment, not hemosiderin, in the hepatic cells around the central vein. MCD picked up his chart by mistake and compared the findings with those of Case 2.

Case 2. Andrew Y, born in 1916, had been seen by WPW in 1950 with right upper quadrant abdominal pain. No jaundice was noted. In 1951 MCD saw him with the same

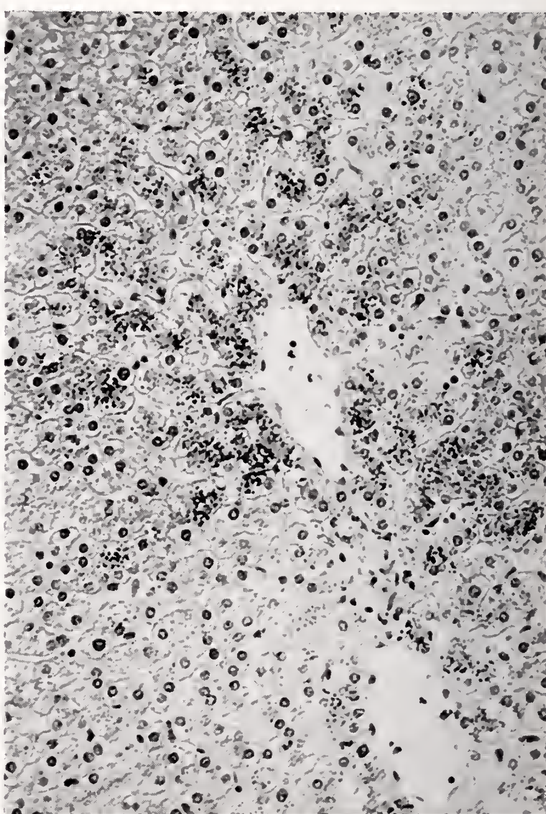

Figure 3. Andrew Y., Liver Biopsy August 3, 1951. H & E Stain. Granular pigment in liver cells around central veins.

complaint. He stated that he had become jaundiced two days after appendectomy in 1944. He stated that he had lost 42 pounds in the year 1950-1951, and had had pale stools and dark urine intermittently. During an anicteric period cholecystography revealed a poorly functioning gallbladder. In August 1951,

Table 1: Observations on four brothers with the Dubin-Johnson Syndrome

	Morris	Andrew	Homer	Will Ed
Icterus	1950: 0 1956: +, post op. 1960: +	1944: +, post op. 1950: 0 1951: +, 0	1950: +, post op. 1961: +, post op.	13 times 1960: +, persistent after cholecystectomy.
Dark or bile-stained urine	Off and on for years 1960: 0 1960: + 1960: ++	1950: 0 1951: +	1950: ++	1960: +
Icterus Index			1950: 17.6	
Direct Bilirubin	1960: 2.25-5.8 mgm. %	1951: 6.0 mgm.%	1961: 5.6 mgm.%	1960: 2.1 mgm.%
Indirect Bilirubin	1960: 0.50-2.0 mgm. %		1961: 2.2 mgm.%	1960: 0.3 mgm.%
Total Bilirubin		1960: 3.35 mgm.%		
Porphobilinogen	1960: 0	1951: 0	1961: 0	
Thymol turbidity	1960: 3 units	1960 2.8 units	1961: 0	1960: 5.5 units
Cephalin flocculation				1961: 0
Cholecystogram	1960: No function	1951: Poor function		1960: No function
Exploration	1960: No stones, dark liver	1951: No stones, dark liver	Not explored	1960: Cholesterol stone, dark liver.
Associated features	Diabetes mellitus since 1956		Hyperthyroidism, 1950	

after nine pounds more of weight loss he was again jaundiced. At exploration his gallbladder appeared normal, and contained no stones. His liver was dark, and on microscopic examination showed deposition of a hemosiderin-like pigment in the hepatic cells. In 1960 he was refused as a blood donor at the Garrard Memorial Hospital, Lancaster, Kentucky, because his serum appeared icteric. His total bilirubin was measured as 3.35 mgm.%. Review of his liver biopsy by Dr. McClellan after Morris Y's exploration revealed it to be consistent with Dubin-Johnson syndrome, as was Morris Y's. A hemosiderin stain on the cell block from Andrew's 1951 liver biopsy showed that the pigment is not hemosiderin.

Case 3. Homer Y, born in 1918, was seen by MCD in June 1950 with hyperthyroidism. Eight days after thyroidectomy he developed jaundice. His icterus index was 17.6 and his urine contained bile. The jaundice subsided spontaneously and his signs of hyperthyroidism disappeared. In March 1961 he was again noted to be jaundiced three days after hip nailing. His laboratory findings resembled closely those of his brothers. He stated that he has two sisters and two other brothers none of whom to his knowledge had been jaundiced, but that his oldest brother Will Ed Y, born in 1906, had been jaundiced 13 times after pneumonia and infections, and had had his gallbladder removed.

Dr. Yopp's Case. Will Ed Y had been operated on in Shelbyville, Kentucky, in 1960 for gallstones. A call to the Louisville pathologist who reads slides for Shelbyville resulted in a report similar to the others except for the additional finding of a cholesterol stone. The pathologist called back the next day to say that this man had been seen and reported in this Journal in February 1961 by Dr. Yopp. The patient had had persistent jaundice for six weeks after cholecystectomy. His liver biopsy had been reviewed by Dr. Dubin and found to be consistent with the Dubin-Johnson Syndrome. A brief tabulation of some clinical and laboratory findings in the four brothers is shown in Table 1.

Summary

The metabolic defects leading to jaundice are discussed.

Clinical and pathological findings in the Dubin-Johnson syndrome are cited.

Four jaundiced brothers, three of whose livers were biopsied by three different physicians and ultimately diagnosed as Dubin-Johnson syndrome, are described.

Coexistence of diabetes mellitus and of hyperthyroidism with the Dubin-Johnson syndrome is reported.

The family physician may recognize benign familial defects which mimic more urgent conditions.

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(Continued on page 801)

The Surgical Treatment of Pulmonary Emphysema†

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In cases of disabling localized bullous or peripheral pulmonary emphysema experience suggests that peripheral bullectomy and frothectomy are preferable to external drainage or lobectomy for the palliative surgical therapy.

Definition and Material

PULMONARY emphysema is the name of a disease resulting from the breakdown of alveoli by their rupture to form larger cavities which take up more space in the thorax, but have much less surface area to accomplish the exchange of carbon dioxide and oxygen. The patient attempts to compensate for the increased size of his lungs by pulling the ribs up and the diaphragm down. The findings on examination are dyspnea upon exertion, an increased anteroposterior diameter of the chest, increased resonance to percussion and decreased breath and heart sounds. X-ray shows increased radiolucency over areas of destroyed lung.

As the general population ages we see more of this disease. While it is found predominantly in men, whether it is caused by chemical or mechanical irritants is uncertain.

The therapeutic methods available are only palliative. The valuable medical measures, which are employed first, are beyond the scope of this discussion. Surgical methods are considered in addition to the medical adjuvants when, despite conscientious employment of the latter, the patient is disabled.

The disease under consideration here is acquired, bullous and peripheral diffuse, pulmonary emphysema. This discussion is not concerned with congenital pulmonary cysts, nor with the subpleural blebs which cause spontaneous pneumothorax in young adults. They are different diseases. They are not pulmonary emphysema. They do not present difficulty in surgical management comparable to the problems encountered with the more diffuse breakdown of alveolar tissue. For the pitfalls through which we have stumbled we lay no claim to originality. They parallel those suffered by others.

Method

The antibiotics made it possible for us to gain experience in managing cavitary lung disease such as tuberculosis and lung abscess. We discovered that the patient might benefit from the excision of functionless lung when we found pulmonary emphysema in the course of thoracotomy for other diseases.

Before the days of streptomycin we used to drain pulmonary cavities of infectious origin by a two-stage technique, first making an incision and resecting a short piece of rib to insert and leave against the outside of the parietal pleura a mild irritant such as a surgical sponge, to make an inflammatory seal of the pleural cavity, and a week or so later at the second stage removing the foreign body to pierce the then adherent pleural layers into the lung cavity. To a great extent eventual success with this technique was related to the time and effort spent individually, repeatedly readjusting these orifices, their tubes, bottles and pumps, to make sure they would drain the lesions. If the work was successful the cavities would then,

†Presented at the meeting of the American College of Chest Physicians during the Annual Meeting of the Kentucky State Medical Association, September 18, 1962, in Louisville.

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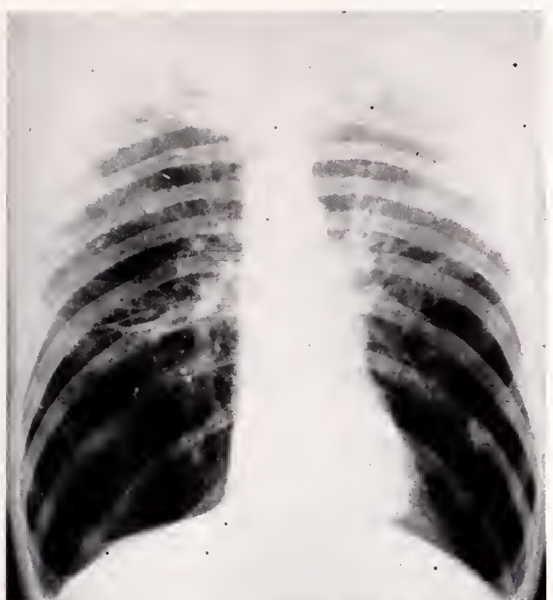


Figure 1. Case 1103, film in full expiration, showing bullae of left lower and right upper lobes, preoperatively.

Figure 2. Improvised flap valve for drainage of bulla.

over a period of months, fibrose, shrink and disappear. When the rationale for the surgical therapy of emphysema became evident, here was a technique which seemed to make sense. To illustrate, three of the cases we have treated surgically in the past seven years will be presented.

Case Report

No. 1103, a 48 year old man, was admitted to the Harlan Memorial Hospital in April, 1956, disabled for a year by dyspnea. There was only a half-interspace excursion of the diaphragm. Radiographically, bullae of the left lower and right upper lobes were identified. (Figure 1) He was so severely incapacitated that at times he would be found unconscious in bed and be revived only by oxygen. In July a two-stage tube drainage of the left lower lobe bulla was completed. At operation its contained air was found to be under positive pressure, and at first of too great quantity to evacuate with the pumps we had. The only conveniently portable one-way air circuit we could devise was to make a flap valve from a condom, with the rounded end cut off, attached to the intercostal drain tube (Figure 2). Within 21 days the air exchange had stopped, and he was discharged, improved.

Three weeks later, August 15, the dyspnea and bulla had reappeared. The tube was reinserted, and within a month the cavity had vanished. In November, six and a half months after we had started treating him, he was doing fairly well, having required no oxygen since the first drainage. In search of additional benefit, we drained in two stages two bullae of the right upper lobe through the bed of the sixth rib posterolaterally. While at the operating table elevation of the shoulder kept the scapula out of the way, when he relaxed postoperatively the drainage tube lay obliquely subscapularly, causing persistent pain. When he lowered his shoulder the motion would pull the tube partway out, so that when he coughed or strained, air from the cavity dissected tissue planes, producing subcutaneous emphysema. It was difficult to replace the tube. He told the nurse that if she would not remove it, he would. At 3:30 A.M. November 3, two days after surgery, he was found sprawled across his bed, dead, the drain out. Autopsy revealed a tension pneumothorax on the right and multiple bilateral bullae up to 10 centimeters in diameter, especially in the upper lobes.

The problem here was related to selection of procedure. With the drainage technique diagnosis can never be as precise as by open thoracotomy. This case revealed that subscapular cavities are not amenable to venting techniques because the drain tubes are intolerably painful. This patient should have had an open thoracotomy for excision of all his bullae, not piecemeal treatment of only the largest cavities which presented radiographically.

During this eight month period he was hos-

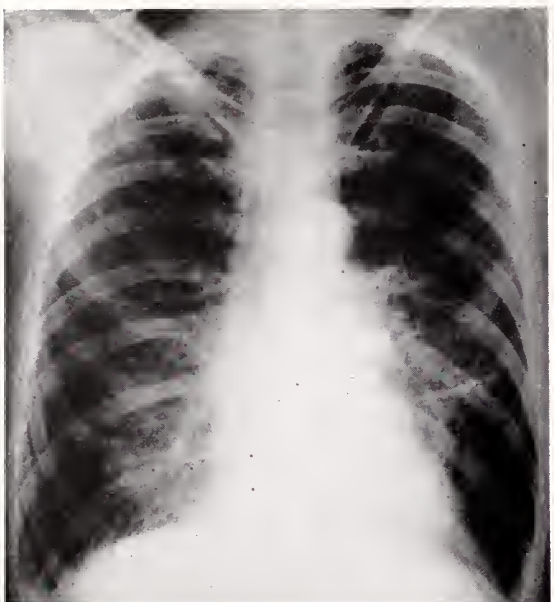


Figure 3. Case 5456, seven years after right upper lobectomy elsewhere, showing emphysematous bullae, 14 July 1958.

pitalized 68 days and made 17 out-patient visits, an expensive proposition. Had open bullectomy been performed initially, he might have required but half the quantity of care and a better result might have been achieved.

To evaluate apparently good surgical results, symptomatic improvement is a poor guide, because the patient usually claims to be better, even though objective studies fail to show improved values for arterial oxygen and carbon dioxide, residual lung volume and maximum breathing capacity. Consequently, search for the truth about benefit from surgery for this disease requires objective physiological data.

Second Case Report

No. 5456, a 50 year old man, was admitted to the Harlan Memorial Hospital for the sixth time in June, 1958, bedridden, with bullous emphysema, especially of the left upper lobe, which herniated to the right. Asthmatic since 1945, he had had a right upper lobectomy elsewhere in 1951 for a "cyst" (Figure 3). In two stages a tube was inserted into the largest left upper cavity, which freely exchanged air with the bronchus. Revisions of this drainage by operation were required on four occasions. Within three months, by September 26, there had been marked shrinkage in the size of the bulla, but though the drain tube was left in, the cavity enlarged again. In December, a bronchogram and planigrams showed large posterior bullae. Pulmonary function tests at that time revealed his vital capacity to be 58% of predicted, residual volume 67% of total lung capacity, maximum breathing capacity 29% of predicted. In the face of rapidly progressing disease, we felt that excision of the peripheral disease offered the only hope. Consequently, in January, 1959, open thoracotomy was made on the left and the bullae were unroofed simply by cutting them off with a large scissors. Surprisingly, there was little bleeding and no excessive air leakage. The few small blood vessels and visibly leaking bronchioles were ligated. The visceral pleural edges were not approximated. The chest was closed with adequate drainage attached to the Emerson vacuum-cleaner type of pleural suction pump which promptly achieved good expansion. Five weeks postoperatively he could walk a block in five minutes and slept on but two pillows. Six months postoperatively, although he felt that he required oxygen at home from time to time, he had taken up quilting for occupation.

Within two years of that first bullectomy the symptoms had again increased to intolerable proportions. Arterial oxygen saturation at rest was 80%, the arterial carbon dioxide 60 volumes per cent, his residual volume 56% of total lung capacity, and x-ray showed a giant left posterior bulla. On January 23, 1961 this and some smaller anterior ones were excised (Figure 4). By one week later his arterial oxygen saturation at rest was shown to have improved 7%; the carbon dioxide had dropped 12%, and, although his maximum breathing capacity was only 32% of predicted normal, this was 3% better than when tested before his first bullectomy. Cardiac catheterization showed a normal pulmonary artery pressure.

Since that time he has been treated on an ambulatory basis, walks in for his medications weekly, has gained weight and claims he feels better than he has felt in years. Fortunately his disease has not recently shown progression, but despite the benefit achieved by a bold attack in his last two operations upon all grossly visible abnormal parts of the left lung, he still requires all the adjuvant medical measures the internist can provide.

This technique for the excision of peripheral emphysema, called by some "bullectomy and frothectomy," theoretically is preferable to lobectomy or segmental resection for two reasons. First, in such cases, preoperatively the

more normal centrally located alveolar tissue is collapsed and unable to accomplish gas exchange. Postoperatively this residual lung is expanded to resume respiratory function. Cor pulmonale and pulmonary arterial hypertension are thought to be related to pulmonary arterial resistance. Secondly, because the peripheral emphysematous tissue has such a paltry blood supply, its sacrifice does not carry with it the threat of significantly increasing obstruction to pulmonary arterial flow. While theoretically excision of pulmonary segments, by removing major branches of pulmonary arteries from the circulation, might be expected to increase the resistance to blood flow and thus cause cor pulmonale, at the same time it should be admitted that this may not be the most significant etiology of pulmonary hypertension. We do not know how much of a part vascular spasm, kinking and shrinkage of vessels as a result of loss of peripheral elastic pull play in this. Arguments persist about the significance of the role of the autonomic nerve supply in vasospasm as well as in bronchospasm.

The patient just presented is a case in point: Although he showed electrocardiographic and clinical evidence of having cor pulmonale years ago, requiring treatment with digitalis, now that he has had a right upper lobectomy plus Monaldi drainage of one bulla and two frothectomies on the left, recent measurement reveals his pulmonary arterial pressure to be normal.

Except that it may reduce intrapleural pressure, surgical therapy is otherwise unsuited to diffuse, generalized disease. The mere fact of an intercostal thoracotomy will cause some, however slight, decrease of thoracic mobility. The most suitable disease for surgical attack is that which is the most localized.

Localization of pulmonary emphysema can be lobar, or it can be peripheral or any combination of the two. Radiographically, comparing underexposed films taken in inspiration and expiration, and by laminagraphy, enough detail can be shown to enable one to decide where to make the incision. To tell exactly what and how much emphysematous disease to excise, however, requires that the chest be opened for analysis of the gross surgical lesions by direct vision and palpation.

The gross pathology of bullous pulmonary emphysema as it appears at the operating table is not generally appreciated. Soon after the anesthesia is started under positive pressure the patient's general color improves somewhat. As soon as the thoracic cage is opened, however, and the emphysematous lung balloons forth, there is a marked and rapid improvement in the patient's respiratory status. The alveoli in the hilar area, which had been compressed by the emphysematous, inelastic peripheral tissue, now can become aerated by the positive pressure of the anesthetist's apparatus.

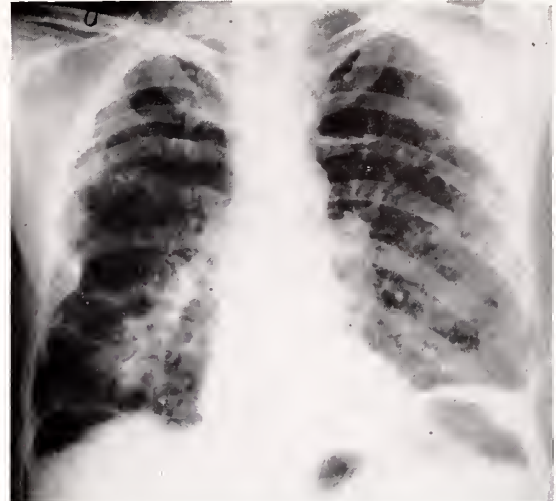


Figure 4. Case 5456 six days postoperatively 28 Jan. 1961, showing absence of bullae in left lung and elevation of diaphragm.

This diseased lung which billows out through the thoracotomy wound presents a pale, translucent gray appearance, unlike the normal pink, or the pink and black of anthracotic lung. To be sure there is some anthracosis apparent grossly in the lung of an emphysematous coal miner, but the blackening is not the outstanding feature. What arrests one's attention immediately is the almost ground-glass appearance of the visceral pleura, and the loose sponginess of the depths immediately beneath. External manual squeezing of this tissue meets with surprising resistance, even when the anesthetist relaxes the positive pressure from the anesthesia apparatus. When one cuts through this attenuated, disrupted alveolar tissue, the firm bulging suddenly collapses and the few filamentary trabeculae fall inward into comparative nothingness.

Third Case Report

No. 10926, a 39 year old man, had been treated medically six years for asthma and emphysema (Figure 5). He had a residual volume 70% of total lung capacity, maximum breathing capacity 12% of predicted, arterial oxygen saturation 81%, carbon dioxide 53 vol-

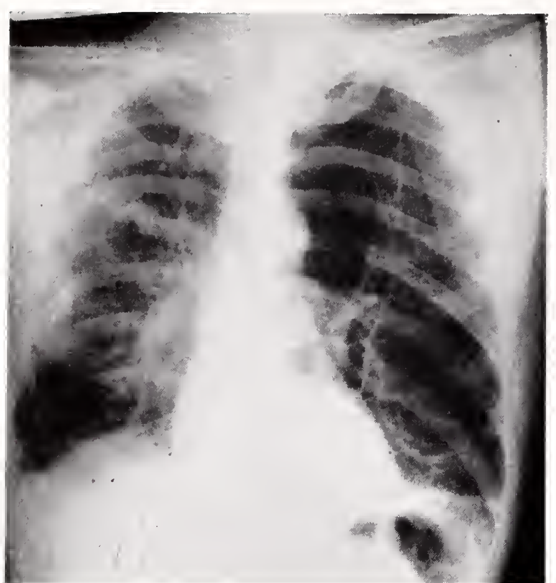


Figure 5a.

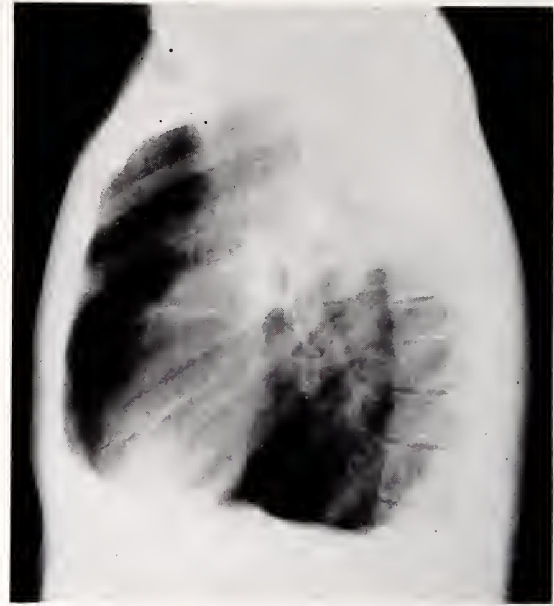


Figure 5b.

Case 10926: Postanterior and right lateral preoperative films showing diffuse basilar emphysema, particularly on the right.

umes per cent. On April 14, 1961, bullectomy and frothectomy were done to the right middle and lower lobes. When discharged three weeks later, there was found to have occurred a change of vital capacity from 32 to 57% of predicted, maximum breathing capacity from 12 to 23% of predicted, residual volume from 70 to 62% of total capacity, arterial oxygen from 81 to 86%, carbon dioxide from 53 to 51%.

His function deteriorated rapidly, however, and by October, six months postoperatively, he required readmission. His maximum breathing capacity had dropped to 7% of predicted, and his residual volume had increased to 76% of predicted. On November 13, bullae and emphysematous peripheral pulmonary froth were cut off from the left side. The postoperative course was complicated by difficulties with pneumothorax and transient paranoia, but within five weeks these had gone. Function studies showed vital capacity to have increased from 41 to 47% of predicted, maximum breathing capacity from 7 to 16% of predicted. The last film, taken in February, 1962, still reveals extensive bilateral lower pulmonary emphysema. He remains in the hospital, and shows evidence of increasing cor pulmonale.

This case demonstrates that the palliative value of excisional therapy may be so short-lived as to raise the question whether the expenditure of effort and taking of risks is worthwhile. In consideration of the alternatives, it seems fair to state that they are. Because it is not established whether further surgery would decrease or increase his cor pulmonale, the question arises whether this man should have both sides revised again.

Indications For Surgery

Not all patients with pulmonary emphysema are candidates for operative treatment. Before they are referred for surgery, three points should be established:

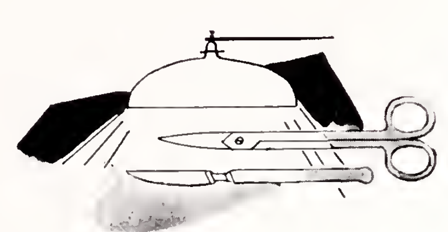
1. That the patient is disabled by the emphysema, and has not been able to carry on satisfactorily with the best medical treatment.

2. That the emphysema is bullous, or if diffuse, at least sufficiently localized that excision of the diseased tissue can, by expansion of the relatively collapsed adjacent, more normal lung and by improvement of diaphragmatic function, be expected to result in improved respiratory exchange.

3. That the surgical facilities under consideration are sufficient to provide exceptional quality and quantity of postoperative care. These patients, because of their low respiratory reserve, are endangered by minimal amounts of postoperative atelectasis or pneumonitis which would not significantly imperil the usual thoracic surgical patient.

Summary

Three illustrative cases have been described to bolster the suggestion that bullectomy and frothectomy are preferable to other measures such as external drainage and lobectomy for the palliative surgical therapy of pulmonary emphysema. Without itself requiring prolonged hospitalization, this procedure removes encroaching, functionless diseased tissue, allowing the more normal lung to expand, fill the space vacated and accomplish respiratory exchange.



Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

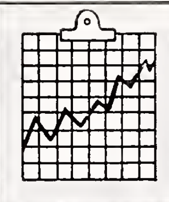
Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

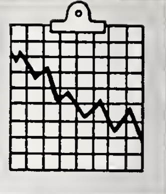
All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.





CASE DISCUSSIONS

From The

University of Kentucky Hospitals

University of Kentucky Medical Center

Hemobilia*

HEMOBILIA consists of massive hemorrhage into the bile duct which in turn results in life threatening hematemesis. Its importance lies in its recognition as a surgically curable disease. The following case report is illustrative of the syndrome and serves to remind the practicing physician of the clinical appearance and therapeutic approach to this condition.

Case Report

S.D., a 19-year-old girl, had a closed abdominal injury in an automobile accident August 23, 1962. A few hours later laparotomy revealed a laceration of the left lobe of the liver which the surgeon repaired with deep sutures and drainage. Convalescence was uneventful except for a mild unexplained episode of hematemesis a few days following operation. She was discharged from the hospital nine days following injury.

Seventeen days following operation she had upper abdominal pain followed by a massive hematemesis, melena and deep shock. Transfusions were given and she recovered. Three days later she was clinically jaundiced and her icteric index was 35 units.

For two months she was asymptomatic but on November 24, a similar episode of abdominal pain, hematemesis, melema and shock occurred. Again massive transfusions were necessary.

A fourth life threatening hemorrhage occurred on December 2, at which time laparotomy was undertaken and because of a suspicion of duodenal ulcer, a vagotomy and pyloroplasty was performed. Convalescence was uneventful.

*This Case Report and discussion is a summary of one of the Surgical Grand Rounds held each Saturday morning, 9-10:00 A.M. by the Department of Surgery, University of Kentucky Medical School.

Her fifth episode of bleeding occurred on December 17, and was accompanied by fever to 105°F., hematemesis and shock. She was transferred to the University of Kentucky Hospital on December 20, 1962.* By this time she had received a total of 30 blood transfusions.

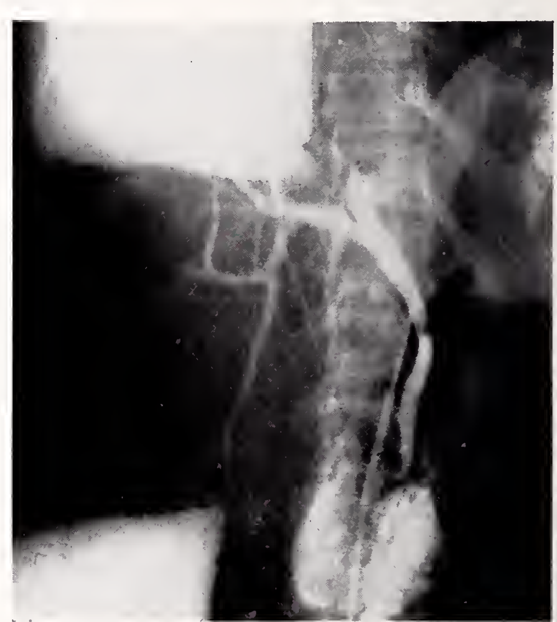


Figure 1.

The evening of admission she had another massive hemorrhage and again required transfusion. The working diagnosis was hemobilia but planned radioactive liver scans were postponed because of her critical condition. An emergency upper gastrointestinal series ruled out varices. Operation was performed on December 22, 1962 with arrangements made for an operative cholangiogram.

At laparotomy the gallbladder was thick walled and contracted. Aspiration revealed old

*Referred by R. H. Weddle, M.D., Somerset, Kentucky.

blood, the left lobe of the liver was firm, suggesting post-cholangitic cirrhosis. In order to localize the source of intrahepatic fistula between the vascular tree and the bile duct, an operative cholangiogram was performed which showed no filling of the left hepatic duct (fig. 1). The common duct was opened, but at first revealed no fresh bleeding. While dissecting out the hilar vessels preparatory to left hepatic lobectomy, massive amounts of bright red blood issued from the left hepatic duct. Pressure occlusion of the porta hepatis did not entirely stop the bleeding. In subsequent mobilization of the left lobe of the liver a 15 cm. cavity was unroofed which occasioned furious hemorrhage from within but which revealed a three mm. artery emptying into the cavity which in turn emptied into the bile ducts. Direct ligature of this vessel restored hemostasis and an orderly left lobectomy of the liver was then possible.

A T-tube was inserted in the common duct, and the liver bed drained. Convalescence was uneventful and the patient discharged two weeks thereafter. She has been entirely well since.

Discussion

Hemobilia usually occurs following closed trauma to the liver. Although approximately 30 cases have thus far been reported in the literature, it undoubtedly is much more common than this would indicate, for many cases must have gone unrecognized or discovered only at autopsy. The importance of its recognition is, of course, its surgical curability.

The history is usually diagnostic, consisting of severe closed abdominal trauma with laceration of the liver requiring lapartomy for control of hemorrhage. Following hepatic suture, the patient usually recovers only to have subsequent episodes of life threatening massive upper gastro-intestinal hemorrhage. Characteristically this is associated with right upper quadrant pain, tenderness and occasionally jaundice. Between episodes of bleeding, the patients may be perfectly asymptomatic.

The fistula between a branch of the hepatic artery and an opening in the bile duct usually occurs in a clot filled cavity within the liver substance.

The differential diagnosis of a patient with massive upper intestinal hemorrhage following abdominal injury consists of 1) a stress ulcer and 2) esophageal varices. Stress ulcers—common following burns—are uncommon following injury.

The treatment of the condition once recognized is operative at the earliest reasonable moment. Since at the time of operation it may be difficult to find the site of hemorrhage within the liver, all measures must be taken to localize the site prior to laparotomy. This will include 1) an exact history as to the site of previous hepatic laceration and suture repair, 2) radioactive chromic phosphate scan of the liver, 3) careful observation and palpation of the liver at laparotomy, 4) splenoportography and 5) operative cholangiography to demonstrate a filling defect within the liver substance.

Once localized, the site of intrahepatic bleeding should be widely exposed controlling the bleeding point with subsequent excision of the hepatic segment as indicated.

In controlling bleeding from the liver it should be remembered that 10%-15% of normal individuals have an aberrant artery running into the liver from the left gastric artery so that occlusion of the porta hepatis may not totally stop bleeding from the liver substance.

Summary

Hemobilia consists of bleeding from the liver into the biliary tree. The condition results from a fistulous communication between a branch of the hepatic artery and the bile ducts and usually follows severe abdominal trauma. It is clinically manifest by recurrent episodes of life threatening upper gastro-intestinal hemorhage.

The importance of recognizing this condition lies in its complete surgical curability.

A case of hemobilia is described and its surgical management discussed.

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Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

In Kentucky

SEPTEMBER

19 University Surgery Day, University of Kentucky, Lexington, Ky.

23-26 KSMA Annual Meeting, Phoenix Hotel, Lexington, Ky.

27 Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

OCTOBER

4-5 Sudden Cardiac Death Conference, University of Kentucky Medical Center, Lexington, Ky.

10 Maysville Seminar, Kentucky Academy of General Practice, Mason City Health Building, Maysville, Ky.

17 University Surgery Day, University of Kentucky, Lexington, Ky.

18-20 Pediatrics Postgraduate Course, U. of L. School of Medicine, Children's Hospital, Louisville, Ky.

23 Review of Current Problems in Obstetrical Anesthesia, U. of L. School of Medicine, Louisville General Hospital, Louisville, Ky.

24 Rural Health Conference, Jenny Wiley State Park, Prestonsburg, Ky.

24-26 Hematology Course, University of Kentucky, Lexington, Ky.

25 Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

NOVEMBER

6 Annual Fall Clinical Conference, Lexington Clinic, Lexington, Ky. Morning: Rheumatoid Arthritis; Afternoon: Specialized Diagnostic Techniques.

9 Regional American College of Physicians, Holiday Inn, Lexington, Ky.

14-16 Clinical Application of Newer Immunological Concepts, Department of Pediatrics, University of Kentucky, Lexington, Ky.

21 University Surgery Day, University of Kentucky, Lexington, Ky.

29 Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

DECEMBER

5-7 The Family Physician's Role in the Pre and Post Operative Patient, Department of Surgery, University of Kentucky, Lexington, Ky.

19 Annual Postgraduate Seminar, Norton Memorial Infirmary, Louisville, Ky.

19 University Surgery Day, University of Kentucky, Lexington, Ky.

27 Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

Surrounding States

SEPTEMBER

20-21 National Rural Health Conference, Arlington Hotel, Hot Springs, Ark.

OCTOBER

2-3 Gastroenterology: Diseases of the Small Intestine, Cleveland Clinic Educational Foundation, Cleveland, Ohio.

5-10 American Academy of Pediatrics, Palmer House, Chicago, Ill.

5-11 Annual Otolaryngologic Assembly, University of Illinois College of Medicine and Illinois Eye and Ear Infirmary, Chicago, Ill.

21-24 Interstate Postgraduate Medical Association of North America, Chicago, Ill.

24-26 Annual Course in Postgraduate Gastroenterology, American College of Gastroenterology, Shoreham Hotel, Washington, D.C.

28-Nov. 1 American College of Surgeons, Brooks Hall, San Francisco, Calif.

NOVEMBER

11-15 American Public Health Association, Kansas City, Mo.

18-21 Southern Medical Association, Municipal Auditorium, New Orleans, La.

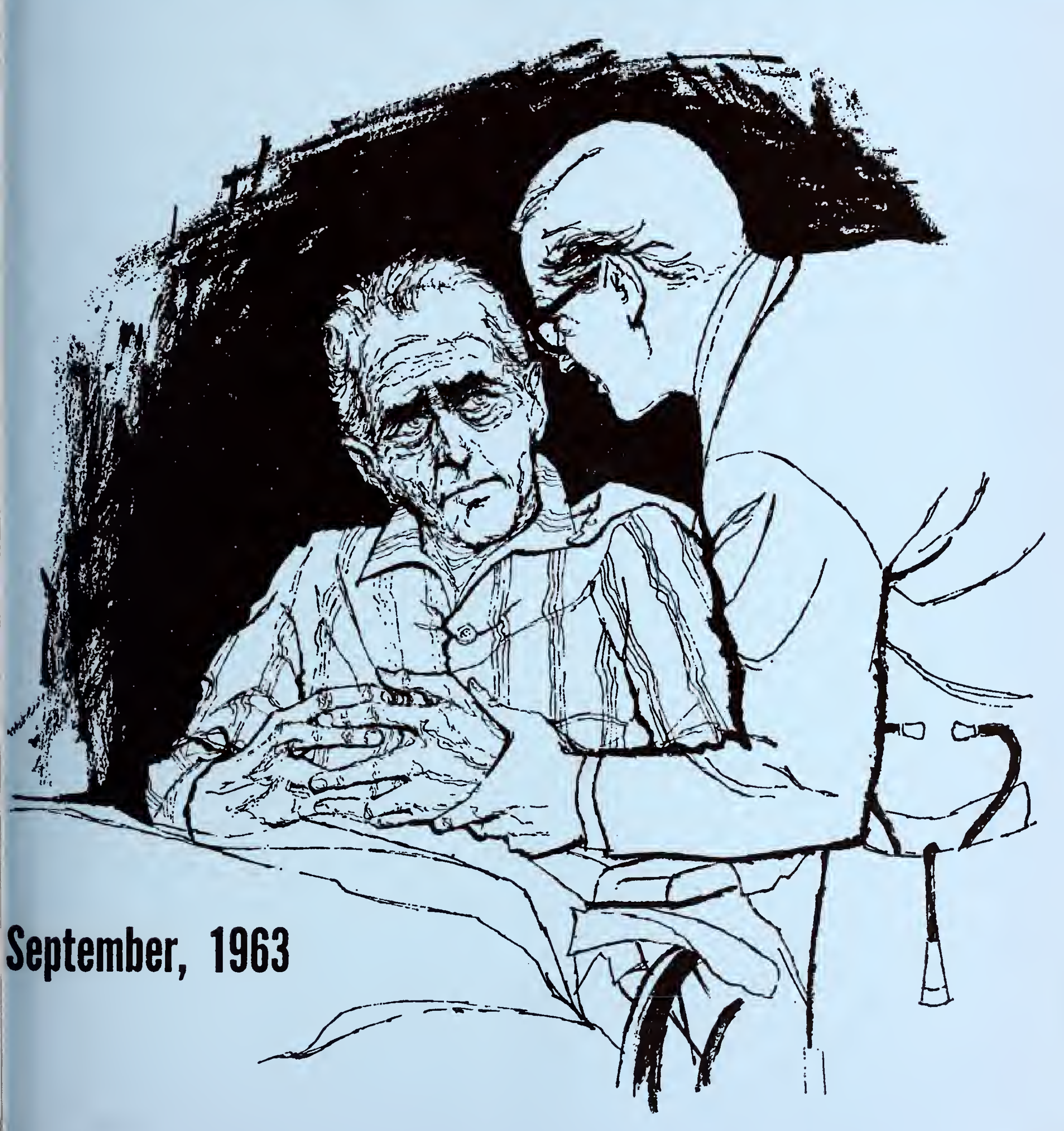
DECEMBER

1-4 American Medical Association (Clinical Meeting), Memorial Coliseum, Portland, Ore.

10-12 Southern Surgical Association, Hot Springs, Va.

SPECIAL BLUE SHIELD ® SECTION

For the Journal of the Kentucky State Medical Association



September, 1963

BLUE SHIELD PLANS

ROLE OF THE AMERICAN MEDICAL ASSOCIATION IN BLUE SHIELD

In 1934 the House of Delegates of the American Medical Association adopted a set of ten principles for the development of medical service prepayment plans. Some of the more important of these principles were:

All features of medical service should be under the control of the medical profession.

No third party must be permitted to come between the patient and his physician in any medical relation.

The patient must have absolute freedom to choose any participating physician.

The confidential nature of the patient-physician relationship must be preserved.

Medical Service should be paid for by the patient in accordance with his income status and in a manner that is mutually satisfactory.

In 1943 the AMA established a Council on Medical Service and Public Relations. Its functions were: to serve as a clearing house for information regarding provision of medical care to the American people; study and suggest means for the distribution of medical service to the public consistent with the principles adopted by the House of Delegates; to assist the state and county medical societies in their activities with relation to medical service.

The Council formulated a preliminary set of "Standards of Acceptance for Medical Care Plans." Plans which met these standards were granted the privilege of using the "seal of acceptance" of the Council on Medical Service. Some of the standards were:

Approved by the local state or county medical association.

Responsibility of the medical profession for the medical services included in the benefits.

Free choice of physician.

Maintenance of the confidential patient-physician relationship.

Maximum benefits consistent with sound financial operation.

Benefits may be in terms of either cash indemnity or service units.

Sound enrollment and administrative practices.

Acceptance of Plans by the Council was ordinarily for "a period of two years or until revoked."

In December, 1945, the House of Delegates instructed the AMA Trustees and the Council "to proceed as promptly as possible with the *development of a specific national health program, with emphasis on the nation-wide organization of locally administered prepayment medical plans sponsored by medical societies.*" Accordingly, in 1946 a central coordinating organization known as Associated Medical Care Plans, Incorporated, was established. The corporate name, Associated Medical Care Plans, Incorporated, was changed to Blue Shield Medical Care Plans in 1950, and in 1959, the name was again changed to the National Association of Blue Shield Plans.

The by-laws provide that the association shall undertake and promote research and statistical services; consultation and information services; public education activities and coordination and reciprocity arrangements between Plans relating to the interests of subscribers.

BLUE SHIELD AND THE FUTURE

Blue Shield Plans have and will continue to be an important factor in the development of our voluntary health care prepayment system in the future. Through these Plans, the physicians serving as their sponsors will exercise the enlightened leadership essential to the preservation of those values inherent in private medical practice which have helped our nation achieve the most progressive medical system in the world, and in addition, help keep the economic control of medicine in the hands of the profession.

BLUE SHIELD BEGINNINGS

The first Blue Shield Plan was organized in California in 1939. Physicians in that state felt there was as much demand for medical prepayment as there was for the prepayment of hospital care. They were also convinced that this demand could best be met through voluntary action by medical societies.

As a result, California Physicians' Service was established in 1939. It was the first Blue Shield type prepayment plan, and operated on a not-for-profit basis. The California Medical Association advanced the funds needed to get the Plan under way.

California Physicians' Service entered into agreements with Blue Cross Plans in California providing for joint efforts in the enrollment of persons who wanted protection against the cost of hospital and medical care. Most Blue Shield Plans that followed entered into similar agreements with local Blue Cross Plans.

In March of the next year, a similar program was organized by the Michigan State Medical Society. Following the lead of California and Michigan, other states and some county medical societies organized similar prepayment plans. Each Plan was established as a separate corporation. Rates, benefits, methods of reimbursing physicians and other details varied from state to state, but all such Plans had one important feature. They were all sponsored by the local medical profession.

This sponsorship has been a most significant factor in the development of the Blue Shield movement, for in this way the physicians themselves determine the kinds and amounts of medical services their patients need and control the development of a prepayment mechanism to meet these needs.

BLUE SHIELD IN KENTUCKY

W. H. Cartmell, M.D., President
Kentucky Physicians Mutual, Incorporated

For some years in Kentucky there was a growing recognition of the need for a method of helping people prepay surgical and medical costs. Recognizing this need, the Kentucky State Medical Association, through its House of Delegates, secured the incorporation of the Kentucky Physicians Mutual, our non-profit Blue Shield Plan, in 1949, and advanced $25,000, which has since been repaid.

In the interest of economy and of efficient operation, arrangements were made for the Plan to be administered by Blue Cross under the control and supervision of the Blue Shield Board, which is composed of 75 per cent doctors and 25 per cent laymen. The Plan has shown a phenomenal growth, and is now paying more than $700,000 every month to doctors for surgical, obstetrical, and in-hospital medical care of its members.

Many dedicated people over the years have given freely of their time and effort to make the Kentucky Physicians Mutual, Incorporated, a success. Chief among these was Oscar O. Miller, M.D., who has sometimes been called "The Father of Blue Shield in Kentucky."

To each of us who plays a part in the operation of Blue Shield, there is a constant opportunity and challenge. Regardless of our responsibility, we are helping people budget in advance for care and to relieve financial hardships caused by serious illness. The service which we are rendering to our fellow man and to the community can be a source of inner satisfaction that makes our job rewarding; also, voluntary Blue Shield is medicine's major bulwark against compulsory medicine.

BLUE SHIELD WAS ORGANIZED BY DOCTORS FOR PEOPLE

Arthur L. Cooper, M.D., Chairman
Enrollment Committee

Active support of Blue Shield helps strengthen and preserve the voluntary system of prepayment and the voluntary practice of medicine. Without Blue Shield, the medical profession will lose economic control of medicine to the insurance companies, industry and labor, or government.

Blue Shield personnel help tell the voluntary prepayment story to employees in over 8,000 firms, to civic, professional and government groups, to doctors and medical organizations, and to the general public.

Blue Shield advertising in more than 50 newspapers, and in business and professional publications, helps to increase enrollment. Increased enrollment helps more people pay for needed care and meet their medical responsibilities.

The preservation of the free choice of doctors and hospitals for *people* is a real bulwark against socialization.

The medical profession, through Blue Shield, can: (1) provide a mechanism to help people budget in advance for necessary health care, and at the lowest possible cost of overhead operation, (2) help design programs in keeping with changes in medical economics, and (3) stimulate commercial companies to improved programs and lower cost.

BLUE SHIELD MEMBERSHIP IN KENTUCKY

Year	BLUE SHIELD MEMBERS
1949	13,562
1950	54,129
1951	101,176
1952	154,424
1953	213,951
1954	287,271
1955	404,431
1956	464,278
1957	507,235
1958	554,586
1959	621,303
1960	702,028
1961	730,883
1962	789,634
1963 (June 30)	807,691

MARCH 31, 1963

Over 26.19% of the Kentucky population are now members of Blue Shield. Nationally, 26.25% of the people are enrolled, or over 48,435,713.

BLUE SHIELD OF KENTUCKY

THE KENTUCKY PHYSICIANS MUTUAL, INC.

1. Paid to doctors in 1962 for services to members: $7,740,216.65.
2. Increase in 1962 over 1961: $973,805.72.
3. 48.94% of amount paid was for surgery done in the hospital.
4. 51.06% of amount paid was for office or home surgery, obstetrical, in-hospital medical, x-rays, anesthesia, and radium therapy.
5. 137,671 new members were enrolled in 1962. Total membership at the end of 1962 was 789,634.
6. Over 8,000 firms in Kentucky now offer the protection to employees on a group basis.
7. 233,113 services were paid in 1962, compared to 208,531 services in 1961.
8. 159 cases per thousand members were incurred in 1962, compared to 153 per thousand in 1961. There were 142 cases per thousand in 1960.

PROPER USE OF PREPAYMENT

Stanley T. Simmons, M.D., Medical Advisor
Kentucky Physicians Mutual, Incorporated

In an era when costs continue to spiral, every effort should be made to eliminate unnecessary medical and health care costs. Voluntary prepayment plans have been developed to help finance necessary health care. Responsibility as a member to make these plans successful involves using, *not* abusing, them. This responsibility carries over to employer, union, and to hospital administrators, as well as physicians and all allied health and medical people.

Physicians, through the American Medical Association, are on record as opposing increasing professional fees just because patients have Blue Shield or insurance. Responsible doctors know that to use Blue Shield or insurance as an excuse to hike professional fees will contribute to the eventual defeat of these voluntary programs.

If everyone with a stake in the success of voluntary prepayment accepts his personal responsibility for making these plans work, the end result will be continually improved voluntary plans more closely tailored to changing needs brought about by technical advances in the medical field.

Some people, forgetting the real purpose of health plans, may attempt to use them for purposes for which they were not intended. The secret of getting the most value for each health prepayment plan dollar calls for using, but *not* abusing, the plan.

PROBLEMS FACED BY BLUE SHIELD

W. Vinson Pierce, M.D., Chairman
KSMA Medical Advisory Commission to Blue Shield

The concept of prepaying for health care has become an accepted part of the American way of life. Because the incomes and needs of people vary, Blue Shield must offer different types of contracts with a variety of benefit levels. Constant study is required in order to keep pace with the economic problems posed by advancing medical science and mounting

costs. The Medical Advisory Commission to Blue Shield attempts to maintain constant surveillance over these factors and assists Blue Shield in developing the necessary programs to fit the needs of the people in keeping with accepted practices of the medical profession.

Competition in the field of prepayment constantly issues new challenges to Blue Shield. Management and Labor negotiated contracts specify the benefits to be included in many health care programs. Blue Shield must be flexible to meet these demands.

Blue Shield has a responsibility to members and regulating agencies to properly administer the public funds with which they are entrusted. The increasing cost of health care is a serious matter to most people. We are challenged to help hold the line on medical costs by constantly helping eliminate unnecessary costs. If professional fees are increased just because people have Blue Shield or Commercial insurance, the concept of prepayment will be eventually defeated. This practice could shatter public confidence if it occurred to any significant degree.

It is impossible for Blue Shield to provide allowances for the whole spectrum of medical care costs. In fact, it is desirable as well as less costly that many charges be paid "out of pocket." There are some people who can afford only a minimum contract—others can afford the maximum. It is vital that Blue Shield dues be kept within the reach of low-income groups on a voluntary basis or else the door is open for some form of compulsory governmental programs.

Blue Shield safeguards the doctor-patient relationship. It was formed by doctors and is directed by doctors, which eliminates the possibility of third party control. As the needs arise, broader coverage for more people will be achieved without sacrificing the goals, objectives, and philosophy of Blue Shield with its desire to help people help themselves.

PROFESSIONAL RELATIONS

Branham Baughman, M.D., Chairman
Professional Relations Committee

Blue Shield was designed by doctors to help people budget in advance for surgical and medical care. The Blue Shield program can succeed only to the degree that it secures the active participation, understanding, and support of the medical profession. We must work closely together to provide the best possible service to the public.

Modern day medical techniques and procedures have offered new challenges to our Blue Shield program in Kentucky. The population explosion and the continous change in marketing conditions requires upgrading of benefits and the broadening of scope and objectives.

Blue Shield is meeting these challenges with amazing success. Many physicians from all over Kentucky have given freely of their time and efforts to foster progress in the field of prepayment, and in so doing, an important favorable image of the medical profession is created.

Blue Shield has demonstrated its ability to offer the people a realistic scope of benefits at the lowest possible cost. New programs have been offered the public in order to keep pace with the needs of the people.

Communication and cooperation between doctors and Blue Shield is vital to the preservation of the voluntary health system. We, on the Professional Relations Committee, believe it is most important that there be a better understanding by all members of the profession as to medicine's basic philosophy in its concept of prepayment plans. Through the planning and efforts of our Physicians Service Department staff, liaison is constantly improving.

The staff makes regularly scheduled visits to doctors' offices. They furnish programs for medical society and medical staff meetings. To answer the need for improving knowledge among the doctors' office assistants, the Physicians Service staff has developed formal Medical Assistants Seminars which are held throughout the State.

More communications avenues will be opened in the future. Blue Shield will continue to face problems, but with improved communications, both doctors and Blue Shield will be in a better position to work together and bring about the best possible solutions.

THE NATIONAL PICTURE

By G. Thomas McKean, M.D.
Board Member, N.A.B.S.P.

During the current struggle to prevent government medicine from inundating the profession, medical leaders have pointed with pride to the strong performance on the part of Blue Shield.

Said Dr. Leonard W. Larson of the American Medical Association:

"Today, the physicians participating in the affairs of Blue Shield and in the American Medical Association represent the two largest groups of physicians in the world. They are dedicated to the preservation of the traditions of American medicine and to the desirability of voluntary health care coverage as an important factor in securing those traditions against the encroachment of compulsory government health care insurance.

"Blue Shield and the A.M.A. are two of the most dynamic forces in our nation today. The development of Blue Shield met with medical support because it clearly followed the concept of providing freedom of choice for the individual. Furthermore, Blue Shield plans insisted that they be financing mechanisms only, and they wisely steered clear of controlling, or attempting to control, the insured person or purveyor of the services.

"Thus, in its few, short years of superb service and phenomenal influence on America's health and economy, the Blue Shield movement has made one of the most significant contributions toward preserving the traditions of American Medicine."

It has been outstanding performance. Since Blue Shield first came into being in the United States, some 48 millions of persons have been covered. Adding this to those who have private insurance coverage, 140 millions of Americans now have some kind of health care **benefits.**

FINANCIAL REPORT

Sound fiscal management has played an integral part in the successful operation of our Blue Shield Plan since its inception. With increased enrollment, new programs, and an ever-increasing volume of claims, diligence in administering Blue Shield funds becomes more important.

During 1962, Kentucky Blue Shield processed claims for 233,113 professional services. This represents $7,131,571 paid to doctors for services to members. With $526,161 paid for the Basic Federal Employee's Plan, and $82,485 for Major Medical and Extended Benefits, the total amount paid to doctors for 1962 is $7,740,216. In addition, $460,407 was paid for the Military Department's Plan, and approximately $700,000 was paid to Kentucky doctors by other Blue Shield Plans.

Since 1949, Blue Shield of Kentucky has paid $44,577,033 to doctors for care, representing 1,408,399 services.

The Blue Shield Finance Committee has a responsibility to see that the funds with which Blue Shield is entrusted are properly administered. Blue Shield operated in the black during 1962 with a net increase in reserves of $338,526.

An investment policy has been established to protect investment principal while achieving a reasonable rate of return on investable funds. Maximum use of available cash, effective and cost-conscious budgeting, and increased efficiency of operation, help Blue Shield to maintain low administrative expenses and to return the greatest amount of the subscriber dollar in the form of benefits for members.

BALANCE SHEET
Year 1962
ASSETS

Cash and Bank Deposits	$ 884,473
Subscription Income Receivable	251,527
Investments	3,579,835
Real Estate	0
All Other Assets	51,411
	$4,767,246

LIABILITIES

Claims Outstanding	$1,248,290
Unearned Subscription Income	824,716
All Other Liabilities	37,490
Reserves Contingency	2,656,750
	$4,767,246

Blue Shield Plans are required to maintain three months of their annual income in reserve. Kentucky has 3.69 months; this represents $3.47 per member reserve.

Kentucky Blue Shield's operating expense per member per month was 9.9 cents while the national average was 14.6 cents. Kentucky ranked 12th among the 75 Blue Shield Plans in low overhead operation.

BLUE SHIELD ADVANTAGES

Young people reaching age 19 or marrying before age 19 may continue membership on a direct payment basis without interruption of protection.

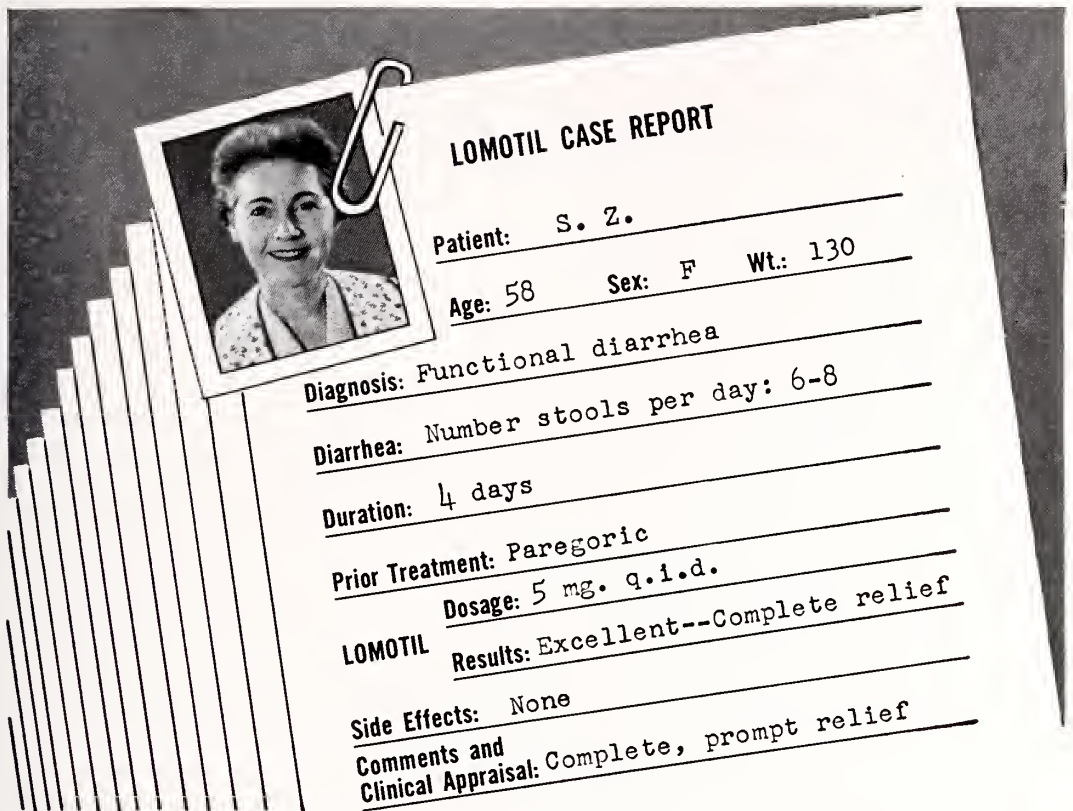
Eligible dependents of deceased subscribers may continue membership without interruption of protection.

Persons retiring or leaving a Blue Shield Group may continue protection on a direct basis. Those who leave a company with a Blue Shield Group and are employed by another company offering Blue Shield may transfer to that Group.

Blue Shield may be transferred from one state to another.

Payments for services are made direct to the doctor.

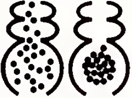
Blue Shield flexibility enables eligible individuals or families to choose from a variety of benefit levels.



To control diarrhea ... promptly

prescribe LOMOTIL® promptly

Each **tablet** and each 5 cc. of **liquid** contains: 2.5 mg. of diphenoxylate hydrochloride (Warning: may be habit forming) and 0.025 mg. of atropine sulfate



The direct, well-localized activity of Lomotil relieves spasm and cramping and provides prompt symptomatic control of virtually all diarrheas.

Numerous investigators have remarked on the effectiveness of Lomotil in patients with diarrhea uncontrolled by other agents.

Weingarten and his associates[1] found it "an excellent drug . . . efficacious where other drugs have failed. . . ."

Hock[2] obtained "results superior to prior medications in 68.3 per cent of 41 patients."

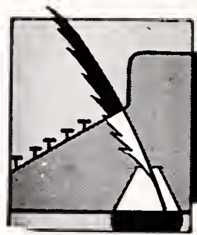
Since Lomotil controls diarrhea so consistently, it is only rational to prescribe Lomotil *before* other agents have a chance to prove inadequate. To control diarrhea promptly, prescribe Lomotil promptly.

Lomotil is an exempt narcotic, its abuse liability being comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of the latter is added to discourage deliberate overdosage.

1. Weingarten, B.; Weiss, J., and Simon, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastroent. 35:628-633 (June) 1961. 2. Hock, C. W.: Relief of Diarrhea with Diphenoxylate Hydrochloride (Lomotil), J. Med. Ass. Georgia 50:485-488 (Oct.) 1961.

G. D. SEARLE & CO.

Research in the Service of Medicine



EDITORIALS

The Vanishing R. N.

DURING the past 20 years attention has been focused upon the increasing demand for an adequate supply of physicians with a concerted effort to increase the opportunities for medical education. This problem is at least on a fair way toward solution. In Kentucky we are in a better position than at anytime during the past generation. Both of our medical schools have enrolled a near capacity Freshman class for 1963, which approaches a total number of 175 students. Moreover, the admissions committees claim that the level of scholarship for the entering class is better than it has been for several years.

The situation with respect to demand and supply for Registered Nurses is far less optimistic. A number of factors have combined to hold down or actually decrease the enrollment of student nurses during the past decade. As has been the case for medical students, it is true for nurses that increased opportunities in business and professional life have attracted many high school graduates who would ordinarily seek to prepare for the profession of nursing.

Many well established hospitals which previously conducted nursing schools have discontinued this because of the expense involved or for other reasons; however, the expansion of nurses' training programs in teaching and other accredited hospitals has actually provided an ample number of opportunities for nurses' training. The real difficulty has been attracting young women to avail themselves of these opportunities.

One deterrent has been the increasing cost of nursing education. A recent bulletin published in the Journal of the American Medical Association has given the cost for three years tuition to range from $100 to $2,200 with a median of $826. No longer is a student nurse able to pay her own way or even receive a small stipend during her years of training in exchange for the actual bedside work she does, as was true a generation ago. Undoubtedly this has been a very real obstacle for many young women who have looked toward nursing as a profession.

The American Medical Association Bulletin tabulates the varieties of training, presenting at least six different categories or avenues by which a student may be prepared for the varying responsibilities and rewards the nursing profession has to offer. Still there is a decreasing number of young women preparing for this profession.

It would appear that the real deficit in these programs lies in the traditional three year training in bedside nursing leading to an R.N. degree. Combined courses leading to a baccalaureate degree have become popular in many institutions and advanced schedules leading to masters or doctoral degrees are designed to supply specialized nurses, educators and administrators in the profession. None of these variations have met with very widespread acceptance although they are based on sound philosophy and planning.

Modifications of the standard course of training leading to R.N. degree have been devised such as shortening the period of hospital training to 2 or 2½ years and supplementing this with a year of practical nursing or internship, for which the student may receive pay. Some state laws require three years of educational preparation for admission to examinations for licensure. What we really need is an increase in trainees and graduates in this particular category.

The high level of patient care which American medicine has attained cannot be maintained without good nursing and this cannot be accomplished without a reasonably adequate number of well trained and highly motivated registered nurses. The demand for bedside nursing has been met after a fashion by the appearance on the scene of the licensed practical nurse. This, however, is not an adequate fulfillment of good medical care. A candidate for licensed practical nurse's training is required to have a

less adequate educational and cultural background and she is generally selected with far less scrutiny than is the candidate for the R.N. degree. Moreover a period of only one year of training is required and less skilled and resourceful care of the patient is expected of her.

A widespread effort at recruitment of medical students and the establishment of loan and scholarship funds have helped tremendously in attracting promising candidates to the study of medicine. It is urgent that we as physicians apply these and any other means at our command to meet the demand for well trained nurses, an essential requirement if we are to maintain and improve our high standards of medical care.

SAM A. OVERSTREET, M.D.

The Purpose of a Medical Record*

THE original purpose of a medical record was to aid the physician in the care of the patient. This included notes concerning the patient's diagnosis, treatment and the progress of the disease process. It was intended to assist the doctor by providing him easily accessible information concerning history and prior treatment. Many records are still kept with only these ideas in mind.

An early by-product was the case report and later, case reports in series. These were written to help the physician in the care of the patient, at more sophisticated level, without significant change either in intent or content.

As the medical record was emerging as a standard instrument in the practice of medicine, an association with the legal profession, perhaps inevitably, developed. It became obvious that an accurate account of a patient's case history was often excellent and irrefutable evidence which could be used to the advantage of this professional group. Such use can be detrimental to the doctor-patient relationship.

Once a patient suspects that what he tells the doctor may conceivably be used to his hurt he becomes circumspect indeed; it is obvious that a document made selectively unavailable may do quite as much harm as if it were made public knowledge. Such a situation does not lead to the confidences that the physician finds so helpful in the practice of his art and which he has every right to expect.

In recent years with the growing emphasis on accreditation and the formation of formidable committees to control approval, another need must be served by the medical record. It is one of the aspects of hospital care that is carefully reviewed by such a group. To comply with the demands of accreditation the text must be fairly rigid in format and completeness is required. These requisites are not always compatible with the best interest of the patient. Brief, concise notations and summations are, under most circumstances, of more practical value.

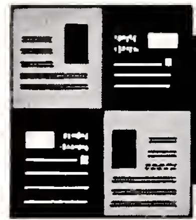
During this same period filing and storage problems have resulted from the ever-mounting hospital population and the attending physician often finds that a chart is unobtainable or, at best, is obtained too late to be of any real help in a given case. We have also grown short of interne-resident manpower. During this period of constantly increasing demand for hospital care a new source of labor had to be found if the directives of accreditation were to be followed. The hospitals found it in the foreign educated interne-resident and in the externe.

Both of these groups have a difficulty in communication, the first because of the language difficulty and the second because of youth. The staffman is, of course, required to read and correct or complete what these young men have written, but, in practice, he rarely does. It would be impossible for a busy man to study the contents of all his charts given the quantitative level that exists today. The result is sometimes confusion added to inaccuracy.

The medical record, then, has been gradually but steadily diverted from its original purpose at the same time that its accuracy has suffered and its volume increased. So long as such diversions do not interfere with the primary purpose they can be tolerated. When they begin to hinder patient care, even though that hindrance may be minor, they should be discontinued or sharply limited. The doctor and his patient do not exist for records; records exist to serve the patient. Whenever we forget that the prime purpose of every activity in the medical field is to improve patient care we have also forgotten what our purpose is.

S. W. WHITEHOUSE, M.D.

**This article is reprinted from the Medical Alumnal Bulletin of the University of Cincinnati, Spring, 1963 edition, S. W. Whitehouse, M.D., Editor.*



SPECIAL ARTICLES

Continuation Medical Education

Nicholas J. Pisacano, M.D.
Lexington, Ky.

THE EDUCATION of a physician is a life-long process; it begins with his collegiate studies and does not end until his physical or intellectual death. The hiatus between available practicable knowledge and its utilization in practice grows exponentially these days. The only bridge across this gap is a continuum of organized and coordinated post graduate programming. The individual physician must be aware of this.

The ideal physician is an amalgam of artist and scientist. On the one hand, he perfects his art through experience, daily contact with patients of all sorts, and, in general, he becomes "seasoned" in the practice of medicine. On the other hand, he must increase his knowledge of the scientific progress in medicine by way of continuing education. The responsibility for continuation of medical education rests on the shoulders of three: the individual physician, organized medicine, and the university.

The physician must be motivated for continuation medical education, and what better motivation is there than the desire to be of the best knowledgeable service to his patients and the love of his art for "wherever the art of medicine is loved, there also is the love of Humanity." (Hippocrates) A sea of knowledge surrounds us, but the unmotivated physician is like the ancient mariner who, having shot the albatross, was left with "water, water, everywhere, nor any drop to drink." Whatever efforts go into post graduate education, in spite of the highest quality of programming, success can come only if the physicians believe the fact that medical education is indeed life-long, that their thirst for new knowledge must be insatiable. An educated physician is the best health measure to his community; conversely, a poorly educated physician is a menace.

Second in this tripartite area of responsibility is organized medicine. Most medical societies, on all levels—local, county, and state as well as national—do make efforts in producing scientific meetings and other educational programs. Witness the founders of the American Academy of General Practice, who with great vision established periodic post graduate study requirements for the maintenance of membership in that organization. Witness also the various specialty societies with their educational programs, journals, etc.

The third partner in the area of responsibility is the university. The ideal university should be a place where, in the words of Thomas Huxley, "a man should be able to obtain instruction in all forms of knowledge, and discipline in the use of all methods by which knowledge is obtained." The University of Kentucky College of Medicine clearly recognizes its responsibilities in promoting high quality programs for graduate physicians. To help meet the educational needs for these physicians, a division of Continuation Medical Education in the College of Medicine has been created and has begun to launch a series of courses, lectures, etc., of all descriptions which should fit the needs and desires of the doctors in the state. The Division is eager for suggestions in planning and conducting programming. Efforts will be made to develop a spirit of cooperation and coordination with the Kentucky State Medical Association, the Kentucky Academy of General Practice, and the University of Louisville, thereby avoiding whenever possible conflicts in scheduling.

Many of the programs offered will be organized so that they may be acceptable for Academy of General Practice accreditation; some will be geared for specialists. It is the goal of the University of Kentucky to present post graduate

medical education that will be timely and practical, striving for excellence and continuity, and hopefully, in a palatable fashion.

In the coming academic year, the University of Kentucky Medical Center is offering a varied curriculum in post graduate education. Below are listed some of the courses planned in conjunction with various departments within the school and through the Division of Continuation Medical Education. Included are the following:

Anesthesiology

The Department of Anesthesiology is presenting a monthly seminar throughout the year. This is open to all who are interested in the field of anesthesiology. Topics for each seminar will vary from month to month and will contain a presentation by a discussant of some interesting topic (such as "electrical anesthesia," "barbiturate poisoning," "prolonged apnea," "fluothane vaporizers," etc.). There will also be case discussions and general participation. Anesthesiologists who attend the seminars are invited to participate by presenting their own interesting cases.

These seminars will be held from 7:00 p.m. to 8:30 p.m. on the following dates: September 12, October 10, November 14, December 12th, 1963; January 9, February 13, March 12, April 9, May 14, 1964.

Medicine

Medicine will begin this academic year a new special "Professor's Day" to be held on the first Thursday of each month. The beginning date will be announced later. This program is designed particularly for those who are family physicians. E. D. Pellegrino, M.D., Chairman of the Department of Medicine, will personally conduct the day's program. A typical day will begin at 8:00 a.m. with rounds by Doctor Pellegrino with the visiting doctors. There will also be presentation of cases of unusual or special interest in the morning. After lunch, there will be a discussion of newer methods in diagnosis, and finally, in the late afternoon, problems in therapeutics.

The Department of Medicine will also offer three concentrated courses during the year. On February 13, 14, and 15, 1964, (two-and-a-half days) there will be a course on "Rheumatic Diseases." On March 12 and 13 (two days) there will be a course in "Hematology," and on June 5 and 6, 1964, (one-and-a-half days) there will be a course entitled "Newer Methods in Diagnosis." Guest teachers from various parts of the United States will participate in presenting these courses.

Pediatrics

The Department of Pediatrics will continue its monthly seminars on the fourth Friday of each month. The dates of these will be September 27, October 25, and November 29, 1963; January 24, February 28, March 27, April 24, and May 29, 1964. (There will be no seminar in December, 1963.) In addition to the monthly seminars, there will be a concentrated two-and-a-half-day course on November 14, 15, and 16, 1963, entitled "Clinical Application of Newer Immunological Concepts." This course will also include guest faculty of national stature.

Psychiatry

The Department of Psychiatry will continue a special "local seminar program" on "Practical Psychiatry." Since the local seminars in the past have been so well received, more than 50 such seminars are being planned in the next ten months in twenty or more different locations in eastern Kentucky. In addition two series of weekly seminars are planned for this fall and next spring to be held at the Medical Center. These will be Thursday night seminars, each on a separate psychiatric subject, designed for the non-psychiatrist, and will involve informal discussion and some case presentations. The dates for these Thursday night psychiatry seminars are as follows: October 24, October 31, November 7, November 14, and November 21, 1963; February 6, February 13, February 20, February 27, and March 5, 1964.

Surgery

The Department of Surgery has designated the third Thursday of each month of the academic year as "University Surgery Day." In an effort to avoid competing with the national and state meetings already established, a different type of program has been set up to allow the practicing surgeon in communities removed from Lexington to be able to come to the Medical Center, participate in the program, and return to his own community in a single day.

The format of the monthly "University Surgery Day" includes observation of operative technique and pathologic processes in the operating rooms during the first part of the morning; the remainder of the morning is devoted to

ward rounds with presentation and discussion of interesting problem cases. The afternoon sessions are devoted to seminars and scholarly presentations by members of the Medical Center faculty and/or their guests on subjects of current interest.

A different topic will be emphasized at each monthly program. Surgeons attending the programs will be urged to present problems from their own practice. The dates for the "University Surgery Days" are September 19, October 17, November 21, and December 19, 1963; January 16, February 20, March 19, April 16, and May 21, 1964. In addition there will be a concentrated course on "The Family Physician's Role in the Pre- and Postoperative Patient" for one and one-half days on December 6th and 7th, 1963.

Basic Sciences

The Continuation Medical Education Division of the University of Kentucky Medical Center is concerned about several requests for reviews in the basic sciences. In accordance with presenting a broad program and the many requests for these courses, there will be presented for this academic year a one day course in pharmacology. The title of this course is "The Contributions of Modern Pharmacology to the Rational Clinical Use of Drugs." This will be held on March 20, 1964 (Thursday). There will also be a week's refresher course in physiology. The title of this course is "Refresher Course in Physiology for the Practicing Physician." The dates of this will be May 18-22, 1964, a five day continuous course.

Distinguished Lecture Series

The University of Kentucky Medical Center has been presenting twice a year, once in the spring and once in the fall, a speaker of international stature to deliver what is known as the University of Kentucky Medical Center Distinguished Lecture Series. (Speakers so far in the series have been Dr. Albert Sabin, Dr. Charles Huggins, and Dr. William Bean.) The tentative dates for the coming year's Distinguished Lecture Series will be October 17, 1963 (Thursday night) at 8:00 p.m. and March 12, 1964. The speakers for these two lectures will be announced in the near future.

Other Facilities

The Division of Continuation Medical Education will also offer for the physicians of Kentucky speakers from our faculty for county medical society meetings, hospital meetings, etc. on request to this Division. There is also anticipated some circuit courses to be given in various parts of the State where a team of faculty members from the University of Kentucky will visit certain centers throughout the State at given times. This is done merely for the convenience of the physicians in the more remote areas and will promote post graduate education at a more convenient location for the physicians during the year.

There is also anticipated what is known as a "clinical traineeship." This is a personal type of post graduate training for individuals who wish specific refresher courses or training in certain areas. This period of time can vary from one week to six weeks and is very similar to a residency without the responsibilities of a resident, and will promote personalized, individualized training in any particular area of medicine desired by the practicing physician.

The physicians in the state of Kentucky will be notified very shortly by means of a brochure detailing the programs and dates of all the above programs. Further information about specific programs may be obtained by writing to the Director of Continuation Medical Education at the University of Kentucky Medical Center in Lexington, Kentucky. It is our sincere hope that the physicians in this state will avail themselves of the many opportunities offered by the Kentucky State Medical Association, the Kentucky Academy of General Practice, the University of Louisville School of Medicine, and the University of Kentucky Medical Center.

Major Medical Libraries in London

Wilhelm Moll, J.D.*
Charlottesville, Va.

THE following account of the major medical libraries in London is designed to acquaint physicians and other health personnel with the larger depositories of medical literature in the British capital. During a stay in that city, in the summer of 1961, I was fortunate in having an opportunity of visiting and re-visiting some of these libraries.

There are over 500 medical libraries in Great Britain. Most of them are small collections. About one half of that number are located in London. Probably the largest collection of medical publications is in the *British Museum,* which, like our Library of Congress, receives copies of every book published in the country. However, it cannot be considered a national medical library; nor is there a separate national medical library, comparable to the United States National Library of Medicine. Medical practitioners will, therefore, need to use some of the other collections, the most important of which will be discussed here.

The largest medical library is that of the Royal Society of Medicine. It is one of several libraries owned by members of private medical societies. Located at 1 Wimpole Street, W.1., this impressive collection has about 400,000 volumes and 2,300 current periodicals. It is administered by Mr. Phillip Wade, librarian, and serves a society of about 11,000 physicians in Great Britain and overseas. Approximately 50% of all requests are handled by mail.

The second largest medical library is that of the British Medical Association containing some 70,000 volumes and approximately 1,600 current periodicals. Located in the B.M.A. House on Tavistock Square, W.C.1., it is under the direction of Mr. F. M. Sutherland. Like the library of the Royal Society of Medicine, this library also engages in extensive inter-library loans and meets requests of out of town members. It is also national in scope and contains recent as well as historical materials.

There are the libraries of the Royal Colleges in London, the Royal College of Physicians of London, the Royal College of Obstetricians and Gynaecologists, and the Royal College of Surgeons of England. All three have historical collections of great value; in addition, the Royal College of Surgeons has an excellent, modern library leaning towards surgery, anatomy, and physiology. Of late, this library is serving the Institute of Basic Medical Sciences of the University of London and the postgraduate students of that school. Located on famous Lincoln's Inn Fields, W.C.2., the library is housed in a beautiful, old building, its main reading room being a wonderful example of the classic style of British library architecture. It was founded in 1800 and has about 120,000 volumes and approximately 500 current periodicals. Its chief librarian is Mr. W. R. LeFanu.

Hunterian Museum

Visitors to the Royal College of Surgery library will also wish to see the great Hunterian Museum which is located in the same building. The museum contains the preparations which were originally built up by John Hunter (1728-1793), following his return from Portugal at the conclusion of the Seven Years' War in 1763. Many other valuable preparations were added after Hunter's time.

London is an important center for the teaching of medicine. There are twelve undergraduate medical schools, each with its own library. Although most of them were founded during the nineteenth or early in the twentieth century, there are some of earlier date, such as St. Bartholomew's Hospital Medical School and Guy's Hospital Medical School. It is an unusual experience to visit a hospital, like St. Bartholomew's, which has existed in its present position since 1123, and whose Medical School dates back to 1662. The library was founded five years later "for the use of the Governors and young University scholars." The library today has some 25,000 volumes and 118 current journals. Its collection includes many valuable early imprints by some of the famous past

**Medical Librarian, University of Virginia School of Medicine; formerly Assistant Medical Librarian at the University of Kentucky College of Medicine*

authors connected with the hospital. The chief librarian is Mr. John L. Thornton who has published an outstanding biography of John Abernethy (1764-1831), whose lectures on anatomy, physiology, and surgery were so popular and attracted such a large number of students that it was found necessary, in 1822, to erect a new and larger anatomical theater. There are some 600 students attending the Medical School which is located at West Smithfield, S.C.1., not far from St. Paul's.

Thane Library of Medical Sciences

Another important college library is the Thane Library of Medical Sciences of the University College on Gower Street, W.C.1. The library is one of the finest pre-clinical collections in Britain. It was originally assembled by Sir George Thane (1850-1930), famous professor of anatomy. The collection is composed of about 25,000 volumes and 290 current journals. Its chief librarian is Mr. C.A.F. Marmoy. While visiting this library, visitors may also wish to see the "auto-icon" of Jeremy Bentham (1748-1832) who may be seen seated in a large case, wearing his clothes and with his stick, "Dapple," in his hand. He is sitting at the south end of the Cloisters in University College. Bentham, the father of Utilitarianism, was one of the founders of the University of London in 1826.

In a survey of London medical school libraries, mention should be made of another important special collection. It is the library of the London School of Hygiene and Tropical Medicine which was founded in 1960 and contains some 38,000 volumes and 540 current periodicals. Cyril C. Barnard who died in 1959 headed this library for many years.

Wellcome Historical Medical Library

One of the great, if not the greatest, library of historical medical materials is the Wellcome Historical Medical Library. The collection was assembled by Sir Henry S. Wellcome (1853-1936), whose ambition it was to obtain the first, or at least a very early, printed edition of every medical work of any consequence! Judging by the holdings which include approximately 250,000 printed books, pamphlets, journals, and 632 incunabula, as well as thousands of manuscripts and letters, Sir Henry appears to have succeeded admirably in carrying out his intentions. The library is housed in a beautiful, modern building on Euston Road, N.W.1., which was opened to readers in 1949. Its chief librarian is Dr. F.N.L. Poynter. A trip to the library will be a rewarding experience for any physician or medical scientist. There is also an excellent Museum of Medical Science and a Historical Medical Museum which are maintained by the Wellcome Foundation.

An important service to medical libraries and students of medicine is performed by Lewis's Medical Scientific and Technical Lending Library. Lewis's is a well-known publishing house and bookseller as well. The lending library sells subscriptions permitting the borrower to take out one item for each subscription. He may retain the volume for the duration of the subscription period, or exchange it for another one as frequently as may suit his convenience. At the time of my visit in June 1961, the librarian, Mr. Hall, told me that there were approximately 100,000 volumes in circulation. Subscriptions run for three months, six months and twelve months. Prices are quite reasonable. For example, a twelve months' subscription for one volume at a time costs 2 pounds 5 shillings, or $6.30. Many libraries have several standing subscriptions at Lewis's and thereby avoid buying frequently revised texts or books of doubtful permanent value. Medical students also have the possibility of renting books which only a few years later may be completely out of date. In this manner Lewis's Lending Library is performing an indispensable service to libraries and students. It is located on 136 Gower Street, W.C.1., close to the University College.

This short resume of London medical libraries cannot do more than cover the highlights of some of the outstanding London collections. It is hoped that American physicians and medical scientists planning to visit the British Isles will find it useful as a guide and assist them in finding some of the greatest storehouses of medical literature in the Western world.

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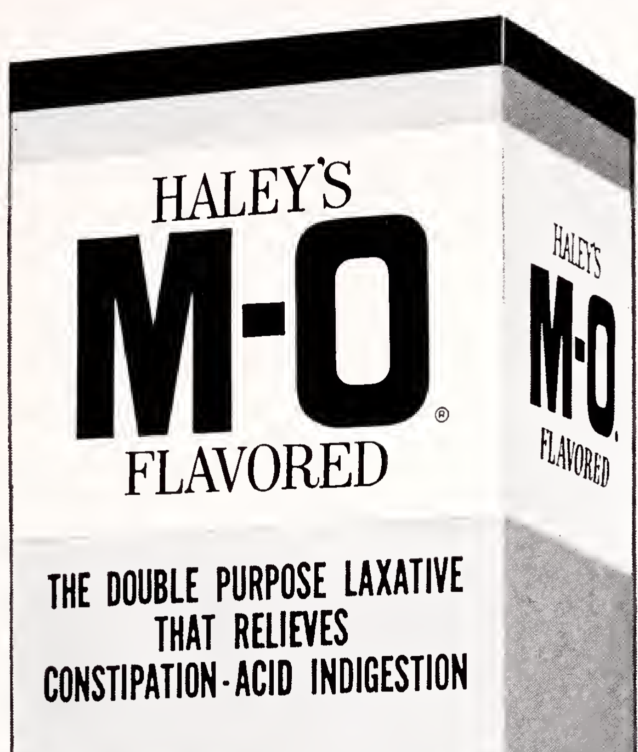

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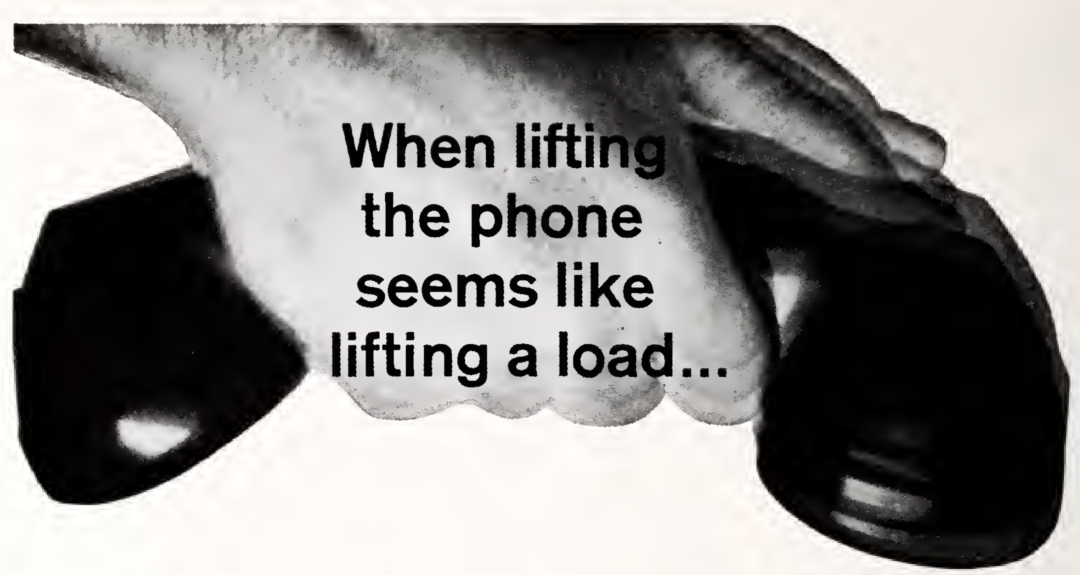

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1. Reeves, J. E.: *M. Times* 90:512, May, 1962. 2. Williams, M. H., Jr.: *M. Sc.* 11: 433, March 19, 1962. 3. Peckenschneider, L. E.: *J. Kansas M. Soc.* 56:486, Sept., 1955.

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ORGANIZATION SECTION

Scientific Program to Feature Color TV, Top Speakers

Four-and-one-half hours of closed-circuit color television, presented as an adjunct to general session seminars, will spark the scientific program of the 1963 Kentucky State Medical Association Annual Meeting, to be held in Lexington September 24-26.

Top national authorities from fourteen specialty fields will also be a feature of the carefully planned, instructive scientific program to be presented.

The TV programs, originating at the University of Kentucky Medical Center Hospital, will be utilized for pertinent case presentations and demonstrations. Two-way communication between the panel in the Crystal Ballroom and the hospital will be possible, so that ensuing discussions will be heard by the audience. A slide-projection screen will be set up to supplement the television screen, so that related slides may be shown during the presentations. The color television programs are being sponsored by Smith Kline and French Laboratories.

How to Live in a Nutty World

"How to Keep From Going Nuts in a Nutty World," will be the topic of an address by Henry M. Johnson, Ph.D., D.D., main guest speaker at the President's Luncheon on Wednesday, September 25. Doctor Johnson, a native Kentuckian and now Minister of Education at the First Methodist Church in Fort Worth, Texas, is nationally known as an after-dinner speaker and lecturer. Presentation of the Distinguished Service Medal, the Outstanding General Practitioner Award, and the R. Haynes Barr Award, will be another highlight of the luncheon program.

A political seminar designed to inform physicians in methods of good political action will be held from 3:30 to 6:30 Thursday, September 26, at the close of the Annual Meeting. The seminar is sponsored by KEMPAC (Kentucky Educational Medical Political Action Committee). A cocktail party and banquet featuring addresses by the Democratic and Republican candidates for the Kentucky gubernatorial election will be given by KEMPAC on Thursday evening. All KSMA members and guests are urged to attend all three functions.

The traditional University of Louisville medical faculty cocktail party for alumni, given this year in honor of former Dean J. Murray Kinsman, M.D., will be held at 6 p.m. Tuesday evening, September 24, in the Georgian Room of the Lafayette Hotel. Following the cocktail party, ten U. of L. classes holding reunions will have special tables during the alumni banquet, beginning at 7 p.m. in the Gold Room of the Lafayette. All KSMA members and their guests are cordially invited to attend both the cocktail party and banquet.

The 1963 KSMA Golf Association tournament will be held as usual during the Annual Meeting. All participants are requested to play their rounds on Monday, September 23, if at all possible.

Luncheons and dinners planned by several specialty groups, combined with other social affairs interspersed throughout the three-day session, will round out the entertainment activities this year.

Ky. Diabetes Ass'n. Program Set for Sept. 23

The Kentucky Diabetes Association will hold its annual scientific meeting at the Imperial House Motel, Lexington, on Monday, September 23, according to William W. Winternitz, M.D., Lexington, program chairman.

The daylong meeting is an adjunct to the KSMA Annual Meeting. Featured speakers include: Harvey C. Knowles, Jr., M.D., professor of medicine, University of Cincinnati College of Medicine; and James B. Hurd, M.D., Chicago, chairman American Diabetes Association Assembly of State Governors and Affiliate Delegates. All physicians are invited to attend and lay members of the KDA and other interested persons are invited to attend the luncheon and afternoon panels.

Following is the program:

Morning Session

Moderator, William W. Winternitz, M.D., associate professor of medicine, University of Kentucky College of Medicine, Lexington

9:30-10:00 **Registration, Imperial Motel**

10:00-10:20 **"Portrait History of Diabetes"**
Katherine L. Sydnor, M.D., asst. prof. of medicine, U of K College of Medicine.

10:20-10:50 **"Care of the Pregnant Diabetic"**
John W. Greene, Jr., M.D., professor and chairman, department of Ob-Gyn, U of K College of Medicine

10:50-11:20 **"Care of the Infant of Diabetic Mother"**
John J. Boehm, M.D., instructor in pediatrics, U of K College of Medicine

11:20-11:30 **Discussion**

11:30-12:30 **"Vascular Complications of Diabetes"**
Harvey C. Knowles, professor of medicine, University of Cincinnati

12:45 **Subscription Luncheon**
"Camping for Diabetic Children"
James B. Hurd, M.D., Chicago, Ill., chairman ADA Assembly of Governors & Affiliate Delegates.

Afternoon Session

2:00-2:45	**"Diabetes Camps Panel"** Moderator, Kenneth Crawford, M.D., assistant professor of pediatrics, U of L School of Medicine (Doctor Hurd will participate)
2:45-3:30	**"Diabetes Detection Panel"** Moderator, Robert Tillett, M.D., instructor in medicine, U of L
3:30-4:00	**Business Meeting** Franklin B. Moosnick, M.D., president, Kentucky Diabetes Association
4:00	**Adjournment**

'63 Ky. Rural Health Conference at Jenny Wiley October 24

The 11th Annual Rural Health Conference is planned for Thursday, October 24 at Jenny Wiley State Park, Prestonsburg, according to James C. Salato, M.D., Columbia, chairman, Kentucky Rural Health Council.

The conference is sponsored by the Kentucky Rural Health Council which was founded in 1951 by the KSMA and now has 25 member organizations. Doctor Salato urges all KSMA members interested in rural health problems to attend.

Area development for Kentucky and a profile of health services and resources in the northeast Kentucky region are among the topics which will be covered during the morning. Governor Bert Combs is scheduled to speak at the luncheon. Audience participation will be a feature of the afternoon program.

Last year's conference was attended by 163 persons representing 36 Kentucky counties.

Collins Estate to Go to U.L.

The estate of the late R. L. Collins, M.D., Hazard surgeon who died May 20 at the age of 83, will be eventually turned over to the University of Louisville "to be used for any Perry County person eligible to attend the University of Louisville School of Medicine," according to the terms of Doctor Collins' will, recently probated.

The income from the body of the estate will go to two heirs, his wife and son, during their lifetimes. The remainder of the estate then will be given to the University for the purpose of aiding in the medical training of any Perry Countian eligible to attend. Doctor Collins was a 1907 graduate of the old Louisville College of Medicine.

The Madison County Medical Society and the Madison County Junior Chamber of Commerce have jointly pledged $2,710 to the Madison County Health Department Building Fund, it was announced recently in Richmond. The money being collected for the construction of a modern health office will be matched by federal and state funds.

New Insurance Review Board Activated by KSMA

Activation of the new KSMA Insurance Review Board was completed at the August 8 meeting of the Board of Trustees when personnel for the new activity was elected, it was announced by David M. Cox, M.D., Louisville, KSMA President.

Officers and members of the Board of Trustees, Doctor Cox said, have long felt the need for this kind of an agency in our Association. He feels the Insurance Review Board will offer another new and very important service to our members and the public.

The role of the new Insurance Review Board is fully described on the Insurance Page (No.   ) of this issue, and Doctor Cox urged that it be carefully read.

Personnel for the new agency will be announced in the October issue of *The Journal*, when acceptances have been received from all members of the seven-man group.

Rural Ky. Scholarship Fund Reports on Progress

Since its inception in 1946 the Rural Kentucky Medical Scholarship Fund program has assisted or is helping a total of 250 medical students needing financial assistance to complete their training. Fifteen of these were new applicants approved for loans this September.

Each recipient accepts two responsibilities to the Fund when receiving a loan. One, he must practice in a qualifying area twelve months for each loan received, and, two, he must repay the money at 2% interest after entering practice unless he locates in designated critical counties. In this case one loan is cancelled for each full year of practice. Of the total number, internships have been completed by 148, of whom 107 are now practicing in Kentucky. Many have completed their obligation. Some have relocated after completing their obligation.

Ninety-four of the 107 are practicing in qualifying areas. Five of the remaining 13 failed to fulfill their moral obligation, but this was before the Commonwealth began to assist the program financially. Remedial action can now be taken by an appropriate State agency on anyone failing to fulfill their obligation.

Of the remaining 102 loan recipients, 55 are now in medical schools and 27 are completing internship requirements. For various reasons 20 have been released or dropped voluntarily from medical schools. The recovery of money from these recipients has been satisfactory.

Of twelve physicians who are in residency training at the present time, four were approved by the Scholarship Fund's Postgraduate Committee. The remaining eight completed their obligation before accepting residency posts. Presently the Postgraduate Committee approves a limited number of residencies per year in Pathology, Radiology, Anesthesiology and ENT.

Fall Clinical Conference Set Nov. 6 in Lexington

The Eighth Annual Fall Clinical Conference, sponsored by the Lexington Clinic and the Kentucky Academy of General Practice, will be held on Wednesday, November 6, 1963, at the Lexington Clinic Building, 1221 South Broadway, Lexington, Kentucky, according to a recent announcement by Leslie W. Blakey, M.D., program chairman.

"The Story of Hypertension" will be the topic of an address by Irvine H. Page, M.D., of the Division of Research, Cleveland Clinic Foundation, who will be the featured guest speaker at the one-day meeting.

The morning session of the meeting will be a two-and-a-half hour seminar on "Rheumatoid Arthritis." "Specialized Diagnostic Techniques" will be the subject of the afternoon seminar. A round-table discussion will take place during the luncheon scheduled between the morning and afternoon session.

This program is approved by the American Academy of General Practice for seven hours of Category I postgraduate education credit.

Athletic Injuries Conference Held In Elizabethtown

An Athletic Injuries Conference was conducted by the Hardin County Medical Society at the Elizabethtown High School Tuesday, August 13 to assist coaches, trainers, and physicians in the treatment and prevention of athletic injuries. Approximately 50 persons were in attendance.

Appearing on the program were seven members of the Hardin County Medical Society, an Elizabethtown Dentist, and George Gumbert, M.D., Lexington, who has appeared on a number of KSMA sponsored Athletic Injury Prevention Conferences. Leslie W. Langley, Jr., M.D., President of the Hardin County Medical Society, was moderator of the program.

R. E. Davis, M.D., Central City, Chairman of the KSMA School Health Committee, was highly complimentary of the Hardin County Medical Society for their successful effort in conducting this first conference to be sponsored by a component society. Doctor Davis urges other county medical societies to conduct similar programs. Other conferences scheduled for this year are at Newport on August 25, Louisville on August 28, and Paducah on September 30.

KAGP Seminar Set Oct. 10

An afternoon and evening program are scheduled for the October 10 Maysville Seminar of the Kentucky Academy of General practice, to be held at the Mason County Health Department, according to Robert M. Blake, M.D., Maysville, program chairman.

"Government Interference in Business" will be the topic of Mr. Roger Fleming, Washington, secretary-treasurer of the American Farm Bureau Federation, who will address the KAGP at a dinner meeting at the Maysville Country Club the same evening. Four major scientific papers will be presented during the afternoon session, which will begin at 1 p.m. Registration for the seminar will begin at noon.

A. Clayton McCarty, M.D. Dies in California

A Clayton McCarty, M.D., 66, retired Louisville internist and 1961 recipient of KSMA's Distinguished Service Award, died August 1 in Los Angeles, Cal., after an apparent heart attack. Doctor McCarty was living in La Jolla, Cal., where he moved in 1962 after retiring from practice in 1959 because of ill health.

Dr. McCarty

Doctor McCarty, a third-generation physician, was a past president of the Southern Medical Association, the American Geriatrics Society, and the Jefferson County Medical Society. He had also served as vice-president of the Kentucky State Medical Association and of the American Therapeutic Society. He was a former associate professor of internal medicine at the University of Louisville and a lecturer in medical economics.

A native of Kentucky, Doctor McCarty received his M.D. degree from the University of Pennsylvania in 1923. He served in both world Wars in all four branches of the armed forces. Doctor McCarty was a founder of the Kentucky Chapter of the Arthritis and Rheumatism Foundation and at one time headed the Kentucky Advisory Committee to Selective Service. He formerly headed the KSMA's first Committee on Aging, and was active in church and community affairs.

Ky.'s Blue Cross Hospital Plan Now in 25th Year

August 1 marked the 25th anniversary of Blue Cross in Kentucky. Originally called "Louisville Community Hospital Service" it was organized on August 1, 1939 as a voluntary hospital prepayment plan, designed to help members pay their unexpected hospital bills by budgeting for them.

It was launched with $1,500 from each hospital and $3,000 borrowed from the Louisville Community Chest. At the time of its founding it had only two employees, including Lane Tynes, the present executive director.

In 1958, the Plan moved to its present home office building on Bardstown Road, Louisville. It now serves over 8,400 groups and 870,000 Kentucky members. Eight branch offices located conveniently throughout the State help keep service at a local and personal level.

Henry B. Freiberg Lecture

Morris Ziff, M.D., professor of medicine at Southwestern Medical School, University of Texas, will speak at the 14th Henry B. Freiberg Lecture at the Medical Auditorium of the Jewish Hospital of Cincinnati on November 4 at 8:30 p.m. Doctor Ziff will speak on "Experimental and Clinical Diseases of Auto-Immunity."

The entire medical community is invited to attend.

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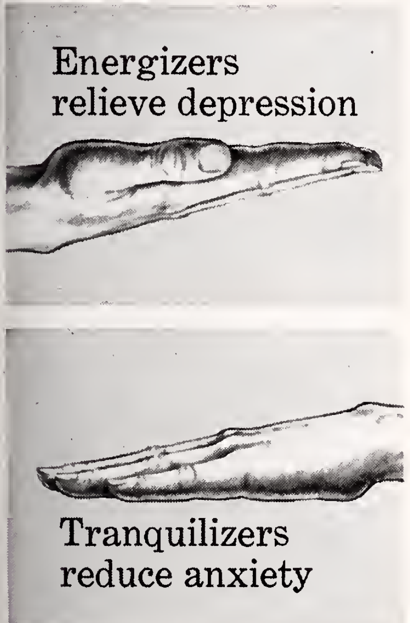

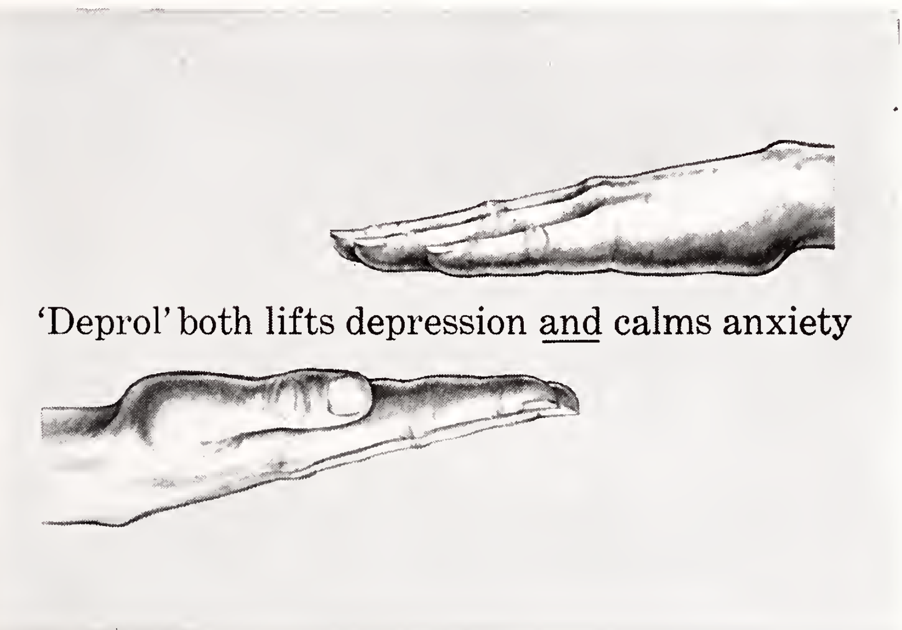

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"Sudden Cardiac Death" Subject of 2-Day Lexington Symposium

"Sudden Cardiac Death" is the subject of a two-day symposium which will be held at the University of Kentucky Medical Center, Lexington, on October 4 and 5.

Under the joint sponsorship of the University of Kentucky College of Medicine and the Kentucky Heart Association, the program will feature 15 out-of-state speakers and five members of the University of Kentucky faculty.

Ventricular fibrillation, ventricular asystole, and clinical considerations will be the major subjects covered on Friday, October 4. On the following day subjects will include coronary artery disease, and prevention and future outlook.

Guest faculty members will include: Samuel Bellet, M.D., University of Pennsylvania, Philadelphia; Baruch Bromberger-Barnea, Ph.D., Johns Hopkins, Baltimore; Leonard S. Dreifus, M.D., Hahnemann Medical College, Philadelphia; A. Sidney Harris, Ph.D., Louisiana State University School of Medicine, New Orleans; Herman K. Hellerstein, M.D., Western Reserve University School of Medicine, New Orleans.

Also, Brian F. Hoffman, M.D., State University of New York-Downstate Medical Center, Brooklyn; Richard Langendorf, M.D., Michael Reese Hospital, Chicago; Eugene Lepeschkin, M.D., University of Vermont School of Medicine, Burlington; Gordon K. Moe, M.D., Masonic Medical Research Laboratory, Utica, N. Y.; Alfred Pick, M.D., Chicago Medical School.

Also, Richard S. Ross, M.D., Johns Hopkins, Baltimore; David Scherf, M.D., New York Medical College, New York; David M. Spain, M.D., Downstate Medical Center, State University of New York, Brooklyn; Demetrio Sodi-Pallares, M.D., National University of Mexico, Mexico City; Paul M. Zoll, M.D., Harvard Medical School, Boston.

University of Kentucky faculty members participating are: Peter Bosomworth, M.D., professor and chairman, Department of Anesthesiology; Alberto Mazzoleni, M.D., assistant professor of medicine, Department of Medicine; Edmund D. Pellegrino, M.D., professor and chairman, Department of Medicine; Frank C. Spencer, M.D., professor of surgery, department of surgery; Borys Surawicz, associate professor of medicine, Department of Medicine.

All applicants should register in advance and a registration fee of $20 should accompany the application. There will be no registration fee for members of the Kentucky Heart Association, house officers, research fellows, graduate students, members of the armed forces, and full-time teachers in medical schools. Applications should be sent to Borys Surawicz, M.D., University of Kentucky Medical Center, Lexington.

Dr. Perry Wins Award

Harold O. Perry, M.D., Rochester, Minn., who will be the guest of the Kentucky Academy of General Practice at the 1963 KSMA Annual Meeting, was one of three Mayo Clinic physicians awarded the Billings Gold Medal for their Scientific Exhibit, "Cutaneous Manifestations of Gastrointestinal Disease" at the AMA Annual Meeting in Atlantic City in June. While attending the Kentucky State Medical Association meeting in September in Lexington, Doctor Perry will address his host group on "Oral, Ocular and Skin Findings in Some Cutaneous and Systemic Diseases," and will participate in General Session panel discussions.

SMA Annual Meeting—Nov. 18-21 in New Orleans

The four-day 57th Annual Meeting of the Southern Medical Association is scheduled for November 18-21 in New Orleans, Louisiana, according to Daniel L. Sexton, M.D., St. Louis, Missouri, SMA president.

The meeting, which annually attracts some 5,000 to 6,000, will feature 48 half-day sessions of 21 medical specialty groups, symposiums on thermal techniques and malignancies, eight closed circuit TV programs, and scientific and technical exhibits. Edward R. Annis, M.D., president of the American Medical Association, will speak at the President's Luncheon on Tuesday, November 19.

Officers from Kentucky who are assisting in the formulation of the program for the meeting are: Councilor: Sam A. Overstreet, M.D., Louisville; Associate Councilors: John B. Floyd, Jr., M.D., Lexington; G. Y. Graves, M.D., Bowling Green; O. Leon Higdon, M.D., Paducah; Charles C. Rutledge, M.D., Hazard; and Carroll L. Witten, M.D., Louisville.

Section officers are: Herman Wing, M.D., Louisville, secretary-elect, section on industrial medicine and surgery; Ralph M. Denham, M.D., Louisville, chairman, section on medicine; Andrew M. Moore, M.D., Lexington, secretary, section on plastic and reconstructive surgery; and W. Vinson Pierce, M.D., Covington, secretary, section on urology.

EKG Course For G.P.s

A basic EKG course for general practitioners will be held each Tuesday morning from September 17 through October 22 at Jewish Hospital in Louisville, according to Norman Blazer, M.D., chief of the department of general practice at Jewish Hospital and coordinator of the program.

The lectures, which will last from 8-9 a.m., will be presented by Morris Weiss, M.D., Louisville. Lecture topics and their respective dates follow: "Normal Values and Measurements", Sept. 17; "Normal Records", Sept. 24; "Angina Pectoris and Masters Test", October 1; "Myocardial Infection", Oct. 8; "Ventricular Hypertrophy", Oct. 15; and "Simple Arrhythmias", Oct. 22. The course is being submitted to the American Academy of General Practice for approval for six hours' Category I postgraduate credit. For further information, contact Doctor Blazer.

Berel Lee Abrams, M.D., has opened his office in Louisville for the practice of general surgery. Doctor Abrams, a 1956 graduate of the University of Louisville School of Medicine, interned at St. Louis Jewish Hospital, following which he was a resident in surgery at Louisville General Hospital.

Digest of the Minutes of the KSMA Board of Trustees Meeting

August 8, 1963

The sixth meeting of the KSMA Board of Trustees was held at the headquarters office August 8 with Keith P. Smith, M.D., presiding.

Robert C. Long, M.D., recently elected as a member of the Board of Trustees of the AMA, was heard briefly, and the reports of the President, the Delegates to the AMA, and the headquarters office were given.

A special request from the Campbell-Kenton County Medical Society was considered and the Board officially thanked the Kentucky Surgical Society for its annual one-thousand-dollar contribution to the McDowell Home Fund.

The final report of the Budget Committee was presented by the Chairman of the Committee, Douglas E. Scott, M.D., trustee from the Tenth District in Lexington, together with the committee's recommendations. (Inasmuch as the Board of Trustees will make a special recommendation to the House of Delegates on the action taken at that time, details of the proposal will not be given here.

The recommendations of the KSMA Memorials Commission to establish life memberships was considered and no action was taken pending the obtaining of a ruling from the Internal Revenue Service.

At the June 6 meeting of the Board of Trustees, as previously indicated, the activation of an Insurance Review Board for the association has been authorized. At the August 8 meeting, personnel for the Board was considered and the following men were elected to serve: Jack Chumley, M.D., Louisville, chairman; Bernard J. Baute, M.D., Lebanon; Harvey Chenault, M.D., Lexington; John Dickinson, M.D., Glasgow; Robert S. Irving, M.D., Louisville; Paul H. Klingenberg, M.D., Covington; and Alfred O. Miller, M.D., Louisville.

A letter signed by twenty-one members of the Bell County Medical Society relating to the future operation of the UMWA Hospital in Bell County and the location of the physicians' office was read and discussed.

Following much discussion, the Board reaffirmed its position in this matter that it had taken at the special April 21 meeting which is as follows:

1. That the patient has free choice of hospital and physician
2. That the medical service be on a fee for service basis, and
3. That there be no physicians offices in these hospitals

The Board devoted several hours to hearing the recommendations of the councils, the committees to the councils, and the standing committees. The recommendations on each one of these committees and councils will appear at the conclusion of the reports of the councils and standing committees.

The Board passed a recommendation made by the Bylaw Committee that the six councils of the association give some study to delineating the duties of the committees under each council and reporting to the Board. The Board would then turn this over to the Bylaws Committee, which would attempt to frame appropriate Bylaw changes to implement these studies at the 1964 KSMA Annual Meeting.

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*Send reservations to:
Alumni office
University of Louisville
Louisville 8, Kentucky.

Postgraduate Meeting to be Held

The 48th annual Scientific Assembly of the Interstate Postgraduate Medical Association, to be held at the Palmer House in Chicago on October 21-24, will offer 20 hours of varied teaching (and AAGP Category II credit) for a registration fee of $10. The program is closely related to the medical problems of the generalist. Those interested in the full details of the program are urged to write for a brochure. Address a post card to N. A. Hill, M.D., Secretary, Interstate Postgraduate Medical Association, Box 1109, Madison 1, Wisconsin.

MEDICAL SCHOOL NEWS
U.K. Opens Obstetrics Unit

With the activation of the obstetrics department at the University of Kentucky Medical Center Hospital on July 3, all major medical services at the hospital are now open, according to recently received information. The department is under the direction of John W. Greene, Jr., M.D., chairman and professor of obstetrics and gynecology.

Ten beds are now open in the obstetrics department, with 16 more scheduled to open eventually. The remaining spaces will be activated as successive College of Medicine classes grow in number.

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Much has been said and more has been written about the quality of, and the motives behind, independent drug research in this country. So we decided to take a look at what we, as an industry, have done in terms of medical progress over the years.

We made a list of the most frequently prescribed drugs of 1962. We gathered them together to take the picture you see on this page. Then we eliminated all products introduced more than 10 years ago. *But then, for the camera to make the labels legible, it became necessary to eliminate several more.*

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For comprehensive control of the whole pain complex...

Like a triad, the action of Trancogesic is direct and simple as 1,2,3. Its tranquilaxant component – chlormezanone – 1. reduces emotional reaction to pain . . . 2. decreases skeletal muscle spasm . . . and 3. its aspirin component dims the patient's perception of pain. Thus, Trancogesic controls the *whole* pain complex – *with unsurpassed tolerance.*

Each tablet of Trancogesic contains 100 mg. of chlormezanone and 300 mg. (5 grains) of aspirin. The usual adult dosage is 2 tablets of Trancogesic three or four times daily. Reactions to Trancogesic have been minor – gastric distress, and an occasional weakness, sedation or dizziness. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. Trancogesic is contraindicated in persons known or suspected to have an idiosyncrasy to aspirin.

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CHLORMEZANONE with ASPIRIN
*TRADEMARK 100 MG. 300 MG.

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Scientific Exhibits Committee

Benjamin B. Jackson, M.D., Chairman

KSMA Headquarters, Louisville **July 18**

The Scientific Exhibits Committee announced at their meeting that a record number of scientific exhibit applications had been received this year. The Committee regretted that a number of these applications could not be approved due to the lack of space available at the Annual Meeting site.

The Committee approved an award to be presented for the best scientific exhibit at the Annual Meeting and it was announced that certificates of appreciation would be presented to all those exhibiting. The Committee's long-standing policy for accepting exhibit applications was reviewed and 17 exhibits were approved for the 1963 meeting.

Council on Communications and Public Service

N. Lewis Bosworth, M.D., Chairman

Louisville **July 11, 1963**

The Council on Communications and Public Service met for its second time on July 11, heard the reports of the committees serving under the Council and made its final recommendations to be presented to the KSMA Board of Trustees and the House of Delegates.

The Council is hopeful that KSMA's two publications, "Newscaps" and "Secretary's Letter," will be combined into a single publication and distributed as the need indicates rather than on a specific date.

After hearing a detailed report submitted by a subcommittee that had been appointed to study Indoctrination programs from other states, the Council recommended that a compulsory Indoctrination Program be initiated by KSMA and that new members be given two years to attend one of several Indoctrination courses.

A motion that KSMA present health exhibits at next year's annual meetings of the Kentucky Education Association and the Kentucky School Boards Association met approval with the Council.

Council on Allied Professions And Related Groups

W. Donald Janney, M.D., Chairman

KSMA Headquarters, Louisville **July 17**

The Council on Allied Professions and Related Groups met July 17 to receive the final reports of the committees serving under the Council. The committee reports were approved as presented and approval by the Board of Trustees was recommended.

The Council, in its final report, recommended that all council and committee members be appointed for the new year prior to the KSMA Annual Meeting of the current year which would enable the committee and council members to meet formally and/or informally during the Annual Meeting to plan activities for the coming year.

Rankin Memorial Research Fund Established at U. of K.

A surgical research fund has been created at the University of Kentucky College of Medicine in memory of Fred Rankin, M.D., nationally-known Lexington surgeon who died nine years ago.

The fund is to be used for supporting research and education projects in the department of surgery which cannot be financed by federal or state funds.

Doctor Rankin, an authority on cancer of the colon, had been president of the American College of Surgeons, the American Medical Association, and the American Surgical Association. He was a former professor at the University of Louisville School of Medicine.

Among those recently appointed by Governor Bert T. Combs to the Kentucky Mental Health Planning Commission were: **Harold L. McPheeters, M.D.,** Louisville, commissioner of mental health; **Irving Gail, M.D.,** and **Logan Gragg, Jr., M.D.,** both of Lexington; **Frank M. Gaines, Jr., M.D.,** Louisville; and **Howard Bost, Ph.D.,** assistant vice-president of the University of Kentucky Medical Center.

Heart Disease, cancer, vascular lesions of the central nervous system, and accidents, account for 71.4% of all deaths in Kentucky, according to the fiftieth annual **Vital Statistics Report** for Kentucky. Recently released by the Office of Biostatistics of the Kentucky State Department of Health, the Report is Kentucky's initial source for birth and death statistics for the 1961 calendar year.

The University of Kentucky medical and dental schools will have 114 students entering this year. Sixty-nine men and five women will enter the College of Medicine's fourth class. The class, to be graduated in 1967, has 57 Kentuckians, 20 of them University of Kentucky graduates. The College of Dentistry's second class will have 40 students, 32 from Kentucky.

The 12th Biennial Rocky Mountain Medical Conference will be held this year from October 30 to November 2 in Las Vegas, Nevada, in conjunction with the 59th Annual Meeting of the Nevada State Medical Association. The conference will feature scientific papers and panel discussions by sixteen nationally known physicians, plus an histologist, embryologist, and a vice-president of a national liability insurance company. For further information write to: Thomas S. White, M.D., General Chairman, Rocky Mountain Medical Conference, 3660 Baker Lane, Reno, Nev.

In Memoriam

EVERETT L. PIRKEY, M.D.
Louisville
1915-1963

Everett L. Pirkey, M.D., 48, nationally-known University of Louisville radiologist, died July 30 after a three-year illness. A 1939 graduate of the U. of L. School of Medicine, Doctor Pirkey had been a faculty member and chairman of the department of radiology. At the time of his death he was a professor of radiology and chairman emeritus of the department. Doctor Pirkey achieved a national reputation as the developer of color X-rays for teaching purposes, as well as in other areas of radiology. He was a leader in the curriculum-revision project at U. of L., which will go into effect this fall.

ARCY O. MILLER, M.D.
Scottsville
1885-1963

Arcy O. Miller, 78, Allen County general practitioner for more than 50 years, died August 1 at Vanderbilt Memorial Hospital in Nashville. In 1955 Doctor Miller was honored by the Kentucky State Medical Association as Doctor of the Year. A graduate of the Medical Department of the University of Louisville in 1911, Doctor Miller was active in civic affairs in Scottsville and Allen County.

WILLIAM R. THOMPSON, M.D.
Lexington
1903-1963

William R. Thompson, M.D., died of an apparent heart attack on Wednesday, August 14. A native Kentuckian, he graduated from the University of Pennsylvania School of Medicine in 1931. A specialist in eye, ear, nose and throat, he was a past president of the Kentucky EENT Society. He was a member of the American Academy of Ophthalmology and Otolaryngology and the American College of Surgeons.

E. DARGAN SMITH, M.D.
Owensboro
1889-1963

E. Dargan Smith, M.D., 74, former health officer for Daviess, McLean, and Hancock counties died August 17, after a long illness. A native of Charleston, South Carolina, he received his medical degree from the University of Louisville in 1916. After spending six years as a medical missionary in China, he practiced surgery in Owensboro from 1928 until 1961. He served as health officer for the three counties until he suffered a stroke in May, 1962. His son, B. Pressley Smith, M.D., practices in Hawesville.

E. E. PALMORE, M.D.
Horse Cave
1871-1963

E. E. Palmore, M.D., 91, retired Horse Cave physician, died July 8 at City-County Hospital in Bowling Green, where he had been hospitalized since June 4. A 1901 graduate of the Hospital College of Medicine in Louisville, Doctor Palmore had practiced in Monroe and Hart Counties for more than 50 years before his retirement in 1953. A son, Cecil E. Palmore, M.D., Bowling Green, died in 1961.

C. L. WOODBRIDGE, M.D.
Middlesboro
1894-1963

C. L. Woodbridge, M.D., 69, Middlesboro otolaryngologist, died August 2 after an illness of several months. Doctor Woodbridge received his M.D. from Johns Hopkins University in 1921, and spent most of his years of medical practice in Middlesboro, though he had also been a medical missionary. An active participant in religious affairs, Doctor Woodbridge was born in China to missionary parents.

County Society Reports

McCracken

Laman A. Gray, M.D., professor of obstetrics and gynecology at the University of Louisville School of Medicine, presented the scientific program at the May 22 meeting of the McCracken County Medical Society held at Boswell's Restaurant. Doctor Gray addressed the members on "Malignancy of the Female."

At the business meeting which followed, it was decided that excess funds gleaned from the Polio Vaccine Drive be disposed of in the following manner: $1,000 to the McCracken County Medical Society Contingency Fund to be used to underwrite strictly medical campaigns or to be given to a health facility as decided by the Society; $1,000 to the Ballard County Mental Retardation Association; $1,500 to the Paducah Association for Retarded School; and $3,000 to the Paducah Mental Health Center.

U.K. Student Gets Scholarship

Miss Lucy Ruth Salmon, Madisonville, a second-year student at the University of Kentucky College of Medicine, has been awarded a $600 Student Scholarship for research and clinical training in the field of allergy by the Allergy Foundation of America. Miss Salmon will carry out her work under the direction of Kingsley Stevens, M.D., associate professor of medicine at U.K.

Francis Brewer, M.D., left the Hyden area in August after completing two years as medical director of the Frontier Nursing Service.

IN THE BOOKS

MODERN CONCEPTS OF HOSPITAL ADMINISTRATION: edited by Joseph Karlton Owen, Ph.D.; published by W. B. Saunders Co., Philadelphia, 1962; 823 pages; price, $16.

This book is the compilation of the opinion of a number of people in the hospital field. Many of these authors are renowned leaders in hospital, nursing and medical thought. Others are comparatively unknown in hospital authorship.

In concept and rendition, this book is a reference volume rather than a textbook on administration. It does not possess the analytical approach of a text such as *Hospital Organization and Management* by the late Malcolm T. MacEachern. It is not so much an analysis of administrative procedures, department by department, but a much broader study of factors which influence hospital operations. The editor uses the "symposium" approach to present concepts and principles affecting hospital administration today. Apparently little or no effort was made to provide uniformity of presentation or to coordinate the individual efforts. The results are thought provoking presentations heavily flavored with individual opinion and experience.

The dominant theme of this book is patient care. Each subject presented is done so in relation to this central theme. Throughout the book efforts are made to ennunciate the means, methods and manners of providing patient care in all areas of service. In addition to chapters on the various direct and supportive services of patient care, chapters on such up to date topics as community planning, financing hospital care services, and current trends in administration are included. Particularly relevant to Kentucky with the recent loss of eleemosynary immunity is the chapter entitled, "The Hospital Insurance Program." This, incidentally, is written by one of the Kentucky authors among the group.

The reviewer's impression is that this book has as its underlying purpose to stimulate thinking rather than instruct. Through the presentation of multiple viewpoints with divergence of opinion the reader is stimulated toward further investigation. On certain controversial issues, several sides have been presented to encourage the reader to determine his own course of thought and action.

In summary, this book effectively presents the hospital as an integral part of the community and considers the field of hospital administration in the light of modern concepts and principles of management. Each individual chapter is patient-centered with emphasis on the hospital's physical, emotional, and economic effect on the individual. The experienced administrator should find this book both stimulating reading and a valuable reference volume. Anyone seeking a general introduction to the field of hospital administration would find it is not, however, a duplication or updating of MacEachern's basic text referred to earlier.

Wade Mountz
Hospital Administrator
Norton Memorial Infirmary

SURGERY IN WORLD WAR II, THORACIC SURGERY, VOLUME I.: Prepared and published under the direction of the Office of the Surgeon General, Department of the Army, United States Government Printing Office Division of Public Documents, Washington, D.C., 1963, 364 pages; price, $4.25.

Thoracic Surgery, Volume I, is the first of two volumes published by the Office of the Surgeon General to tell the story of thoracic surgery in World War II. Colonel Coates and Dr. Berry under the direction of General Heaton, have collected the history of the experiences of eight of the leading thoracic surgeons and their associates in the Mediterranean and European Theatres in the management of patients with injuries of the chest during World War II.

In three parts, the development of thoracic surgery in previous wars, the general and statistical background of World War II experience, administrative considerations in the combat theatres and Zone of the Interior, and the evolution of the final routine of management of thoracic casualties from the emergency battlefield care through their rehabilitation in chest centers is reviewed. Management of special types of chest injuries and complications will be covered in more detail in the second volume of this history.

Included in the volume are emergency measures used in the field, diagnosis, resuscitation and preoperative preparation, anesthesia, initial wound surgery, reparative surgery and reconditioning and rehabilitation.

The management of chest injuries finally agreed on included prompt and adequate debridement, the performance of thoracotomy in forward hospitals only on strict indications to stabilize the cardiorespiratory physiology, prompt and adequate measures to control potentially dangerous complications such as wet lung, management of hemothorax by aspiration and organizing hemothorax and hemothoracic empyema by decortication and judicious removal of foreign bodies whose presence seldom furnished the sole indication for thoracotomy in a forward hospital.

The final section devoted to the often neglected rehabilitation of the patient with chest trauma is excellent, profusely illustrated and recommended reading for all physicians handling these injuries.

There is a moderate amount of repetition throughout the volume which tends to detract from this excellent text. There is also no consideration of the vast Pacific experience of World War II and the possible

effects of the high humidity and heat of this theatre on the chest wounds and their management.

This volume is a valuable addition to the surgical literature and recommended study for all physicians interested in the management of injuries of the chest.

Herbert T. Ransdell, Jr., M.D.

New Books Featured

W. B. SAUNDERS COMPANY features the following new books and new editions in their full page advertisement appearing elsewhere in this issue:

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This new book gives you the best treatments, currently in use by leading authorities, for over 300 diseases and disorders that afflict children.

MAINLAND—ELEMENTARY MEDICAL STATISTICS

A New (2nd) Edition—revised to bolster your statistical thinking and also your use of the standard statistical formulas and procedures.

(Continued from Page 759)

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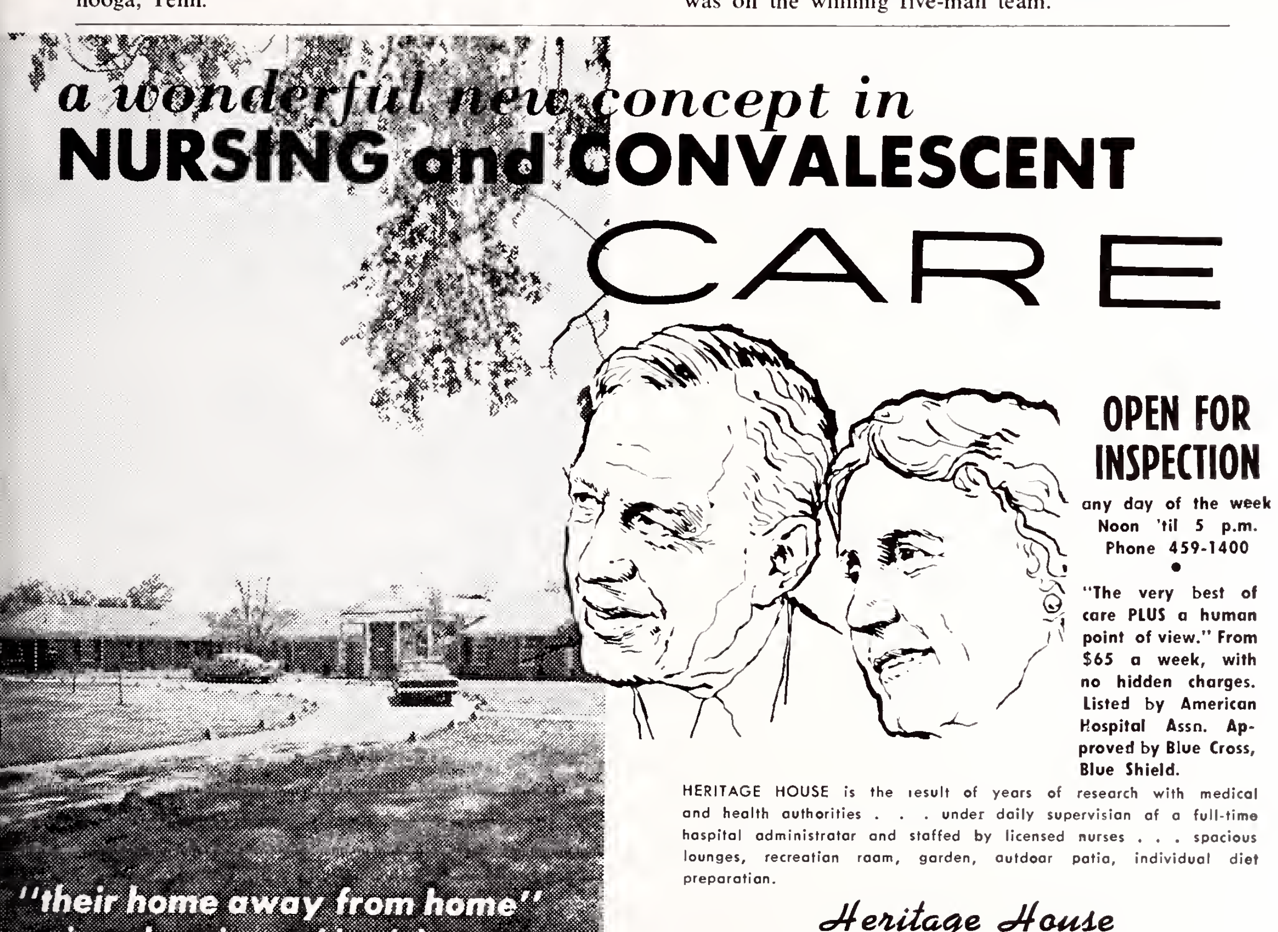
David L. Lawrence, M.D., recently returned to Jamestown, his hometown, where he is associated in general practice with his father **M. M. Lawrence, M.D.** A graduate of the University of Louisville School of Medicine in 1962, he has just completed his rotating internship at Baroness Erlanger Hospital, Chattanooga, Tenn.

Keath Hammon, M.D., Louisville, was the major winner of the West Kentucky Skeet Championships held July 17 at Mayfield, defeating last year's champion Charlie Wilson in a 12-gauge shoot-off after the two had tied in the regular shooting. Doctor Hammon also won the all-around championship, and was on the winning five-man team.



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Side effects and precautions: Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression. Caution indicated in use with depression, suicidal tendencies, peptic ulcer. Minor side effects: diarrhea, weight gain, nausea, drowsiness. Bendroflumethiazide may cause reversible hyperuricemia and/or gout, unmask latent diabetes, increase glycosuria in diabetics. Caution indicated in use for patients on digitalis, with severely damaged kidneys, renal insufficiency, increasing azotemia, cirrhosis. Contraindicated in complete renal shutdown. Minor side effects: leg or abdominal cramps, pruritis, paresthesias, mild rashes.

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News Notes

B. J. Kidd, M.D., has begun the practice of general medicine in association with **M. B. Wilkes, Jr., M.D.,** at Brownsville, according to information recently received. Doctor Kidd, a native of Lerose, Ky., is a 1961 graduate of the University of Louisville School of Medicine. He interned at Louisville General Hospital and served a one-year residency in the University of Kentucky Department of Medicine.

Chris B. Foster, M.D., Glasgow, has opened an office in that city for the practice of otolaryngology, according to recently received information. A native of Glasgow, Doctor Foster received his M.D., degree from the University of Louisville in 1957, and interned at St. Joseph Infirmary in Louisville. His residency was completed at Gill Memorial Eye, Ear and Throat Hospital in Roanoke, Va.

Jack K. Hellman, M.D., has recently become associated with **Fred Barlow, M.D.,** and **Russell Scalf, M.D.,** in Louisville, for the practice of radiology. Doctor Hellman is a 1953 graduate of the University of Louisville School of Medicine, and served his residency at St. Joseph Infirmary in Louisville. From 1954 until 1960 Doctor Hellman maintained a general practice.

Earl Farrell, Jr., M.D., Newport pediatrician, recently attended the 16th annual meeting of the World Federation for Mental Health, held in Amsterdam, The Netherlands. Doctor Farrell attended the session as the official delegate of the American Society of Clinical Hypnosis.

T. M. Perry, M.D., Jenkins, Ky., general practitioner, was recently honored as "Outstanding Citizen of Jenkins" in a proclamation issued by Mayor Don B. Hill. Doctor Perry, a 1927 graduate of the University of Cincinnati College of Medicine, was recognized for his 34 years of faithful service to the people of Jenkins.

James R. Crase, M.D., has recently opened an office in McKee for the general practice of medicine. A graduate of the University of Louisville School of Medicine in 1962, Doctor Crase just completed his internship at Wesley Medical Center, Wichita, Kan.

John Will Taylor, M.D., 84, Stamping Ground, was honored with a "Doctor Taylor Day" on August 11. He has practiced medicine in Owen, Scott, and Franklin counties for the past 60 years. Sponsored by the Stamping Ground Ruritan and Woman's Clubs, the program consisted of a "This Is Your Life" enactment and a reception. He graduated from the Louisville Medical School in 1903.

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For professional samples, just write The Bayer Company, Dept.112, 1450 Broadway, New York 18, New York.

Leonard A. Goddy, M.D., recently announced the opening of his offices in Louisville for the practice of orthopaedic surgery. Doctor Goddy, who is a native of Pittsburgh, Pa., graduated from the University of Louisville School of Medicine in 1958 and interned in Pittsburgh, following which he became an orthopaedic resident in the University of Louisville Hospitals.

Mark A. Judge, M.D., has opened an office at Central City for the general practice of medicine, it was recently announced. Doctor Judge, a native of Boone County, is a 1962 graduate of Vanderbilt University College of Medicine. He interned at Butterworth Hospital in Grand Rapids, Mich.

Raymond E. Hayden, M.D., Barbourville, has opened an office in that city for the practice of pediatrics, according to a recent announcement. A native of Owensboro, Doctor Hayden is a 1958 graduate of St. Louis University School of Medicine, and served both internship and residency at Cook County Hospital in Chicago.

Billy H. Wells, M.D., has recently become associated with **Floyd B. Hay, M.D.,** in Albany, where he will enter into general practice. Doctor Wells graduated in 1962 from the University of Louisville School of Medicine and interned at Robert Packer Hospital in Sayre, Pa.

L. C. Brown, M.D., Henderson County health officer, has resigned to further his studies in the field of public health. He will enroll at Johns Hopkins in Baltimore in the fall where he will study for a masters degree in public health.

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Southwest Kentucky

Due to death an excellent, well established practice of 30 years in ophthalmology and otorhinolaryngology is for sale in a state line community corner of and drawing from 5 counties in 2 states. Rented, air conditioned office equipped and furnished. Potential unlimited.

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Fulton, Kentucky

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Kentucky State Medical Association
3532 Janet Avenue, Louisville, Ky.

New KSMA Members Named

The Kentucky State Medical Association announces the recent addition of 18 physicians to its membership lists. The following are new regular members: Thomas Campbell, M.D., Frank Falkner, M.D., Leonard Goddy, M.D., Marcelle Hamberg, M.D., Robert Keisler, M.D., Joseph Kutz, M.D., Donald Varga, M.D., and William G. Weathers, M.D., all of Louisville; Stephen F. Collins, M.D., Shelbyville; and Paul A. Pichardo, M.D., Glasgow.

New Associate members are: Clementi Oca, M.D., Jeffersonville; Abbas Bashir, M.D., Jeremiah Flowers, M.D., and William Pesci, M.D., all of Louisville.

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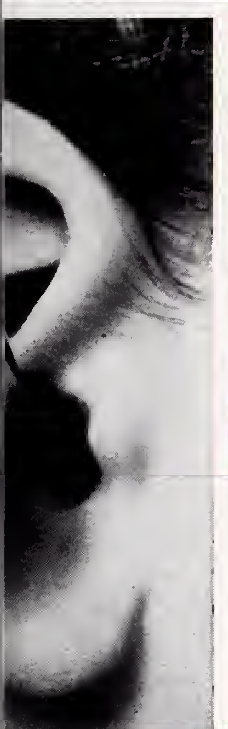

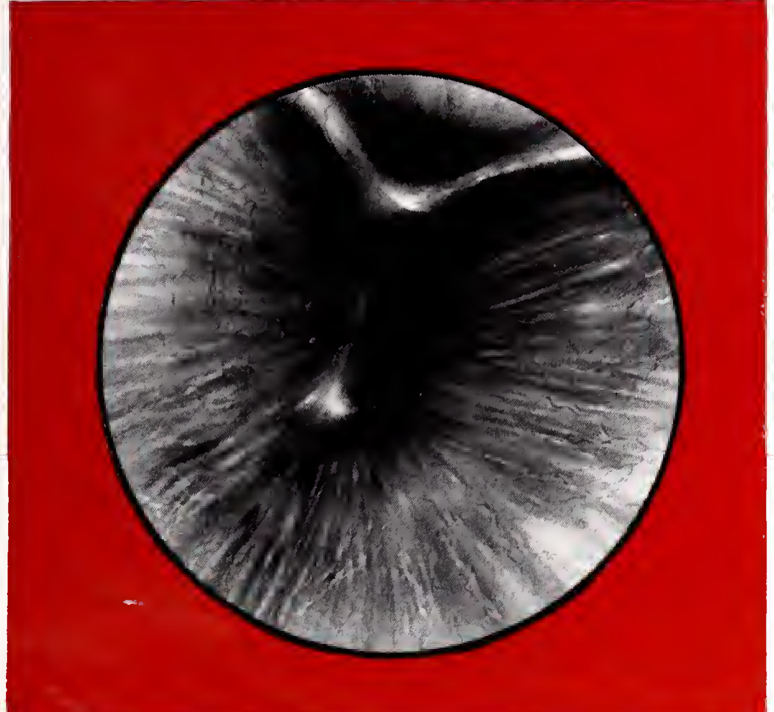

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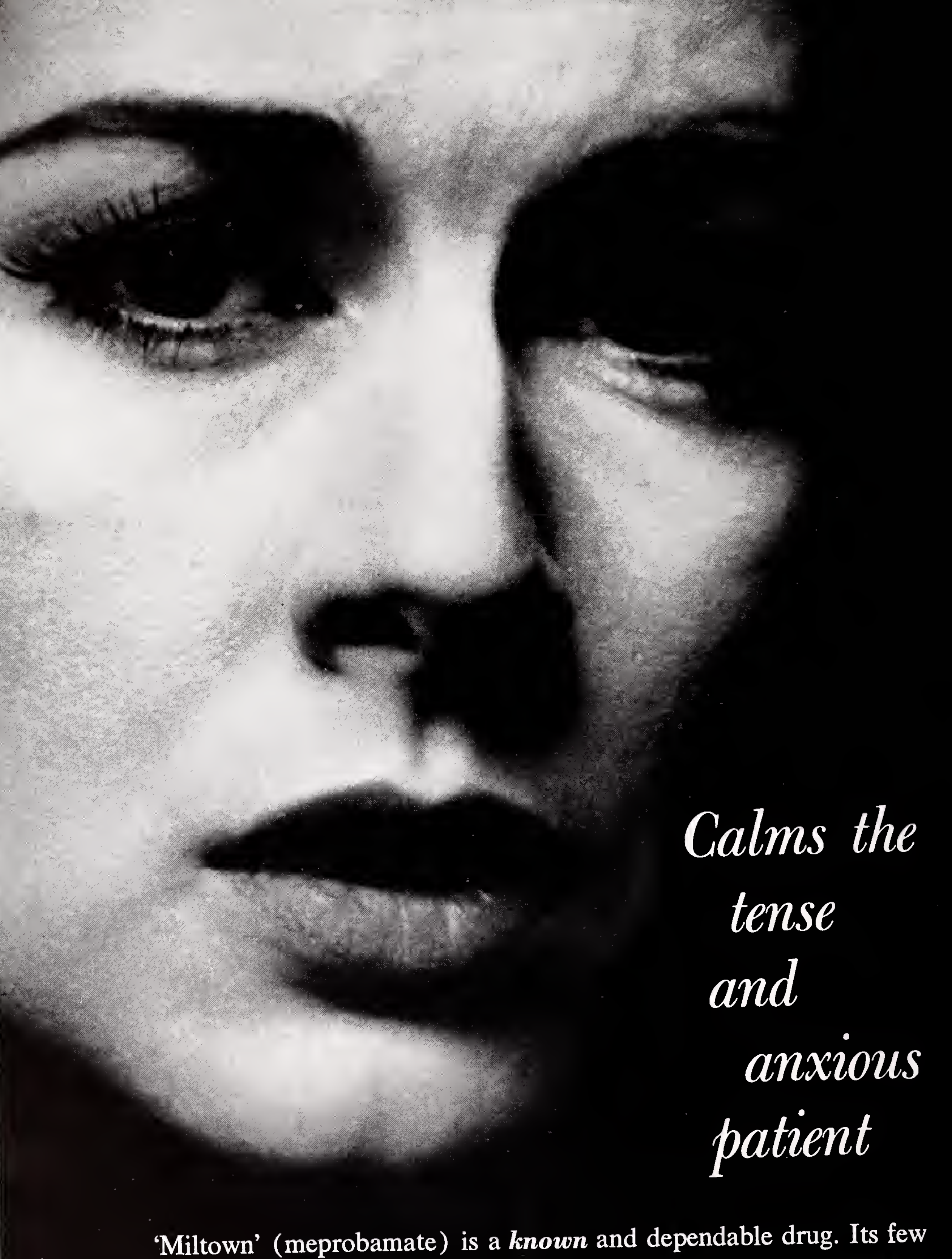

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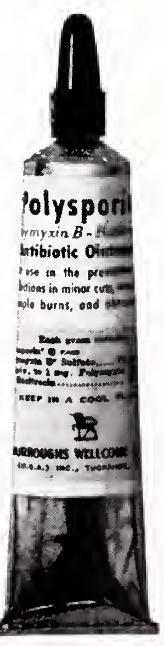

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PUBLIC HEALTH PAGE

PKU Testing Program*

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

THE statewide PKU testing program for newborn infants, sponsored by the State Department of Health, was begun in January of 1962. The procedure is as follows: A "test kit" composed of two strips of Whatman #1 filter paper is enclosed with each birth notification, which is routinely sent out, from local health departments to parents of every newborn child. An instruction sheet is also enclosed telling the mother to place the filter paper in the baby's diaper in order to saturate it with urine, then return after drying to Children's Hospital in Louisville. An envelope already stamped and addressed is included for this purpose. When the test kit is received at Children's Hospital, it is first tested with 10% Ferric Chloride for the presence of phenylpyruvic acid, the presence of which is suggestive of PKU. (However, positive reactions must always be confirmed by repeat urine tests and a blood phenylalanine level.)

Following the Ferric Chloride "spot test" the urine is subjected to a chromatographic examination, ie., a solution of the urine is transferred to a paper chromatogram which can then be analyzed for the presence of phenylalanine and for other abnormal amino acids and sugars as well. At least ten other diseases, in addition to phenylketonuria, are diagnosable by the paper chromatographic technique rendering this method of particular value. These diseases include cystinosis, cystinuria, de Toni-Fanconi syndrome, Lignae's syndrome, gargoylism, maple sugar urine disease, Hartnup's disease, renal tubular disease, glucosuria, galactosemia and fructosuria.

All of these are admittedly rare, as is phenylketonuria, but the possibilities are there. Other diseases, potentially diagnosable by this method, eg., Wilsons' disease and heavy metal poisoning are not of interest in the newborn period.

As of the date* of this writing, Children's Hospital has received and tested a total of 31,198 kits. This represents only about 30% of total births. Three cases of PKU have been identified, but it must be admitted that these cases do not speak well for the success of the program, since only one of the three children was diagnosed at a suffcently early age (three months) to be treated with a maximum of success. The mother of a second child failed to return the kit until the child was eight months of age, when she began to suspect some abnormality. In a third child of ten months the mother was encouraged to return the kit by a public health nurse who had noted the child's delayed development! These two older infants, even though treatment was begun immediately, will undoubtedly sustain some impairment of normal mentality.

The most important factor, accounting for the low percentage of returns, appears to be lack of understanding on the part of parents of the importance of the test. Attempts have been made to correct this by revising and clarifying the instruction sheet, and by widespread educational programs conducted by local health department personnel, assisted by a recent radio and television compaign sponsored by WHAS and a series of state-wide meetings conducted by National Foundation volunteers. Some improvement, as noted by an increase in return of test kits, has occurred.

Another factor affecting the success of the program is the time of filing of the birth certiicate with local health departments by the physician or hospital. Some counties report a delay of as much as six months! Such a delay would obviously affect the success of early

This article was prepared by: Helen B. Fraser, M.D., M.P.H. Director Division of Maternal and Child Health, Kentucky State Department of Health, 275 East Main Street, Frankfort, Kentucky.

August 7, 1963.

case-finding and treatment which should be instituted within the first three months.

Questions have been raised concerning the advantages of this program over other methods such as 1) distribution of test kits from hospitals at time of delivery, 2) Phenistix testing in the physician's office or, 3) a test of the baby while in the hospital. Our thinking concerning these questions are as follows: 1) The time interval occurring between the baby's discharge and the time the test kit should be submitted (not prior to four weeks) may contribute to the mother's forgetting or misplacing it; also, turnover in personnel in most hospitals gives rise to some doubt as to continuity of this method. This method used in other localities has not had a high degree of success; 2) Phenistix or Ferric Chloride testing in the physician's office would, of course, lead to detection of PKU if all babies were seen by physicians for routine health supervision, but unfortunately, this is not true. Figures based on a projection of 1960 census data indicate that 51% of children in Kentucky are not seen by a physician even once yearly. Furthermore, this method would omit testing for the other congenital abnormalities previously listed; 3) A hospital test, which can be done in the newborn period; namely, the Guthrie method, is known, but its reliability has not been completely demonstrated. It is a somewhat difficult technique requiring special training of technicians and its relative expense as a screening method probably places it beyond the attainment of all hospitals in Kentucky. Furthermore, while 97.1% of our births now take place in hospitals, a small percentage would not be reached.

For these reasons, it is our intent to continue our testing program as described here until a better method is available, hoping, perhaps vainly, for an eventual 100% return. The physicians' cooperation can be helpful in, 1) educating patients concerning the value of this test and, 2) in completing and filing birth certificates as promptly as possible.

Donald T. Varga, M.D., has recently become associated with **Arthur T. Hurst, M.D.**, in Louisville, for the practice of internal medicine. A 1957 graduate of the University of Louisville School of Medicine, Doctor Varga completed both his internship and residency at Louisville General Hospital.

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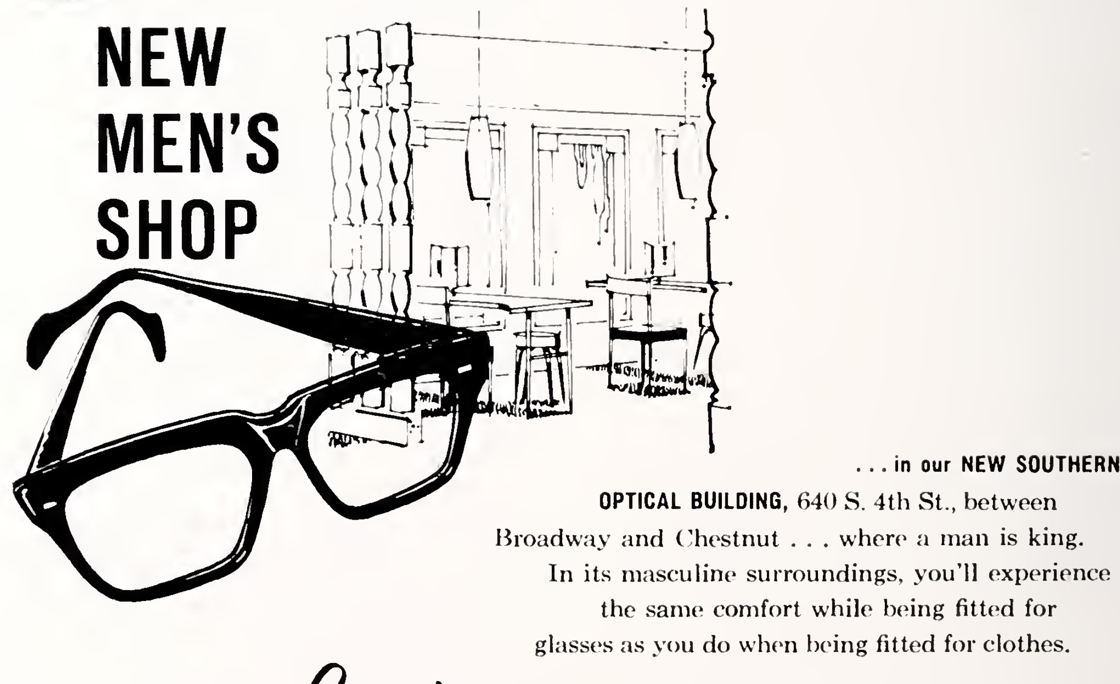

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Pertinent Paragraphs

"Clinicol Application of Newer Discoveries in Enzyme Chemistry" will be the subject of this year's dissertation for the Caleb Fiske Prize of the Rhode Island Medical Society, according to a recent announcement. The Caleb Fiske Prize is America's oldest medical essay competition. The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $500 is offered. Essays must be submitted by December 11, 1963. For complete information regarding regulations, write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

* * *

In terms of dollors, when we controst the scope of our current medical research effort to what we spend on other essential national activities, we are the gnat compared to the elephant. In the fiscal year of 1962, the Federal Government allocated $677 million through the National Institutes of Health to defend us against crippling and killing diseases, as compared with $2.8 billion for our farm price support and related programs. It allocated only $102 million to defend us against cancer the cause of approximately one death every two minutes, compared with $158 million for agricultural research, including the health of cattle and pigs. It allocated $93 million for research against all heart diseases, America's number one killer, compared with $3.5 billion for the improvement of roads and highways.—David Sarnoff at Albert Lasker Medical Research Awards Luncheon, New York, Nov. 14, 1962.

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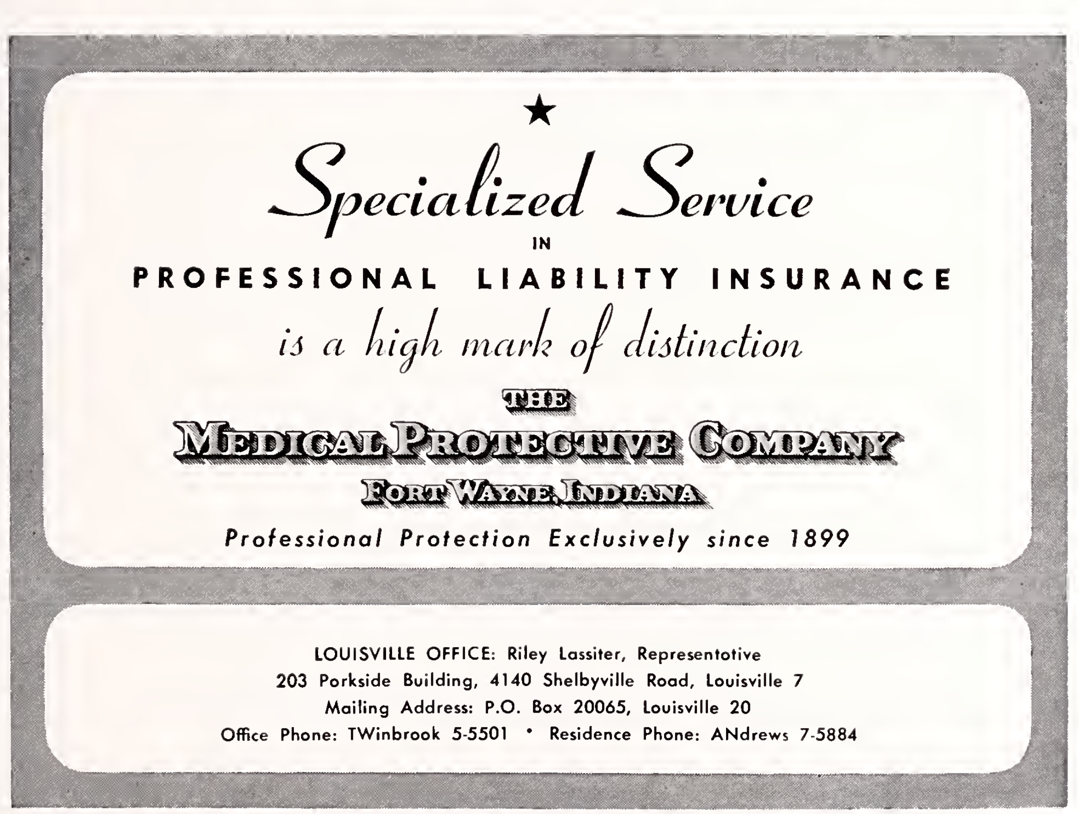
* * *

Horold J. Kososky, M.D., has begun the practice of obstetrics and gynecology in Louisville, it was announced recently. Doctor Kosasky, associate professor of ob-gyn at the University of Louisville, is a 1953 graduate of the University of Manitoba, Canada.



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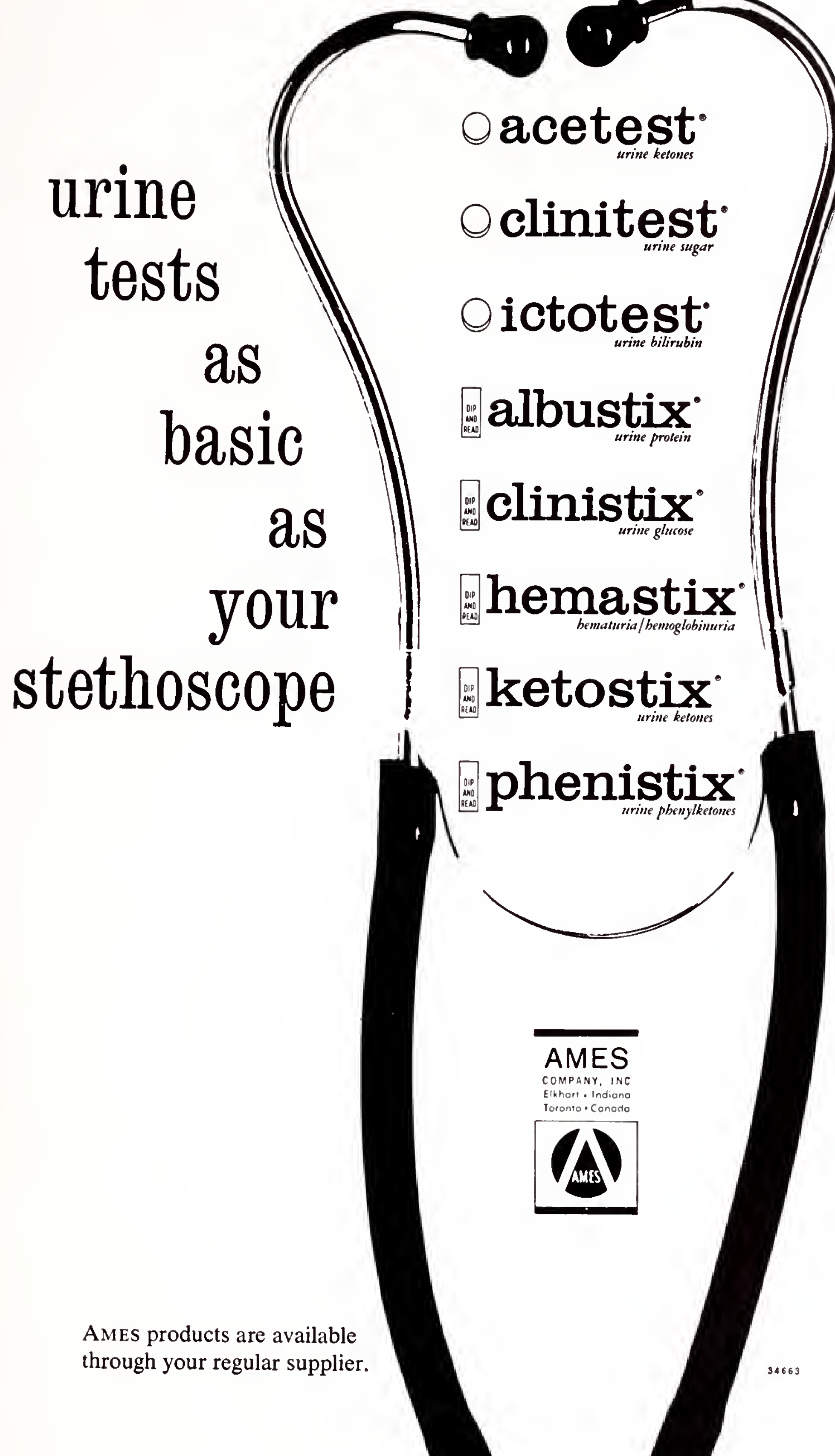
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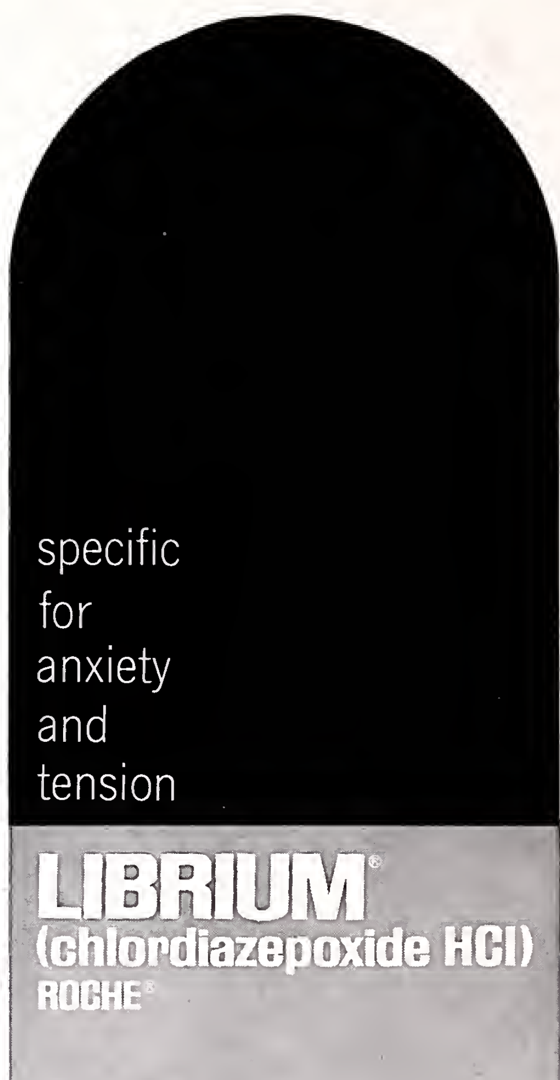

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Symposium on Endocrinology

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in chronic bronchitis and emphysema ISUPREL® hydrochloride BRAND OF ISOPROTERENOL hydrochloride MISTOMETER® Q.I.D.

ISUPREL (isoproterenol/Winthrop) "...can increase breathing efficiency in pulmonary emphysema."[1] The patient with chronic obstructive pulmonary disease "...should use the bronchodilator four times daily whether or not he experiences episodes of bronchospasm."[2]

Use of the Mistometer eases breathing by relaxing bronchospasm, and aiding productive cough. "Of the aerosol bronchodilators, ISUPREL (isoproterenol/Winthrop) seems to be the best...."[3] Conscientious use q.i.d. improves vital capacity and exercise tolerance.

The Mistometer brings new efficacy and convenience—enables patients to maintain treatment wherever they are.

With use of ISUPREL (isoproterenol/Winthrop), occasionally tachycardia, palpitation, nervousness, nausea and vomiting or headache may occur, especially with excessive dosage. Adjust dosage carefully in patients with hyperthyroidism, acute coronary disease, cardiac asthma or limited cardiac reserve, and in persons sensitive to sympathomimetic amines.

Caution: Epinephrine should not be administered with ISUPREL (isoproterenol/Winthrop) as both drugs are direct cardiac stimulants and their combined effects may induce serious arrhythmia. If desired they may, however, be alternated, provided an interval of at least four hours has elapsed.

Dosage: Two inhalations at least one minute apart four times daily, regularly. Inhalations may be taken more often if indicated.

Available as ISUPREL HCl (isoproterenol HCl/Winthrop) Mistometer—single unit combining plastic nebulizer and ISUPREL (isoproterenol/Winthrop) solution 1:400—or 0.25 per cent w/w (=2.8 mg. per ml.), and includes alcohol, 33 per cent; bottles of 15 ml.

1. Reeves, J. E.: *M. Times* 90:512, May, 1962. 2. Williams, M. H., Jr.: *M. Sc.* 11: 433, March 19, 1962. 3. Peckenschneider, L. E.: *J. Kansas M. Soc.* 56:486, Sept., 1955.

Winthrop Laboratories, New York 18, N.Y.

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MESSAGE FROM THE PRESIDENT

The Challenge Ahead

ONE OF THE most difficult problems facing the medical profession today is how to transform new members and old inactive members into well informed and active participants in their local and state medical societies. The challenge is to increase materially the number of members who not only give financial support to the society, but who will take an active interest in its affairs, thereby insuring its future as a strong and effective professional organization.

There are many problems confronting those of us who practice medicine in Kentucky today. To name just a few:

(1) Practice of the art and science of medicine
(2) Working with Medical Schools and Hospitals
(3) Local, State and National Legislative Activity
(4) Insurance, Private and Voluntary
(5) Third Party Medical Programs
(6) Aging and Mental Health
(7) Medicine and Religion
(8) Town and Gown Syndrome
(9) Public and Allied Professional Relations
(10) Finance and Staffing

In fact, the years ahead will require greater and better effort than ever before. Our state and county medical societies need the articulate voices, the helping hands and the sincere dedication of every qualified physician to meet these difficult challenges.

I believe that a refusal to take an active part in our county and state organization is one of our major faults and which can best be summed up in the words of Theodore Roosevelt when he said, "The first requisite of a good citizen in this Republic of ours is that he shall be able and willing to pull his own weight."

GEORGE P. ARCHER, M.D.

Important
news in
cardiac therapy

Two new clinical
reports document
successful long-
term treatment
of ischemic heart
disease with
Persantin®, brand of
dipyridamole

See next 3 pages

Study 1.
Griep, A.H.: Long-term Therapy of Ischemic Heart Disease With Oral Dipyridamole: A Report of Fifty Cases. Angiology 14:484, 1963.

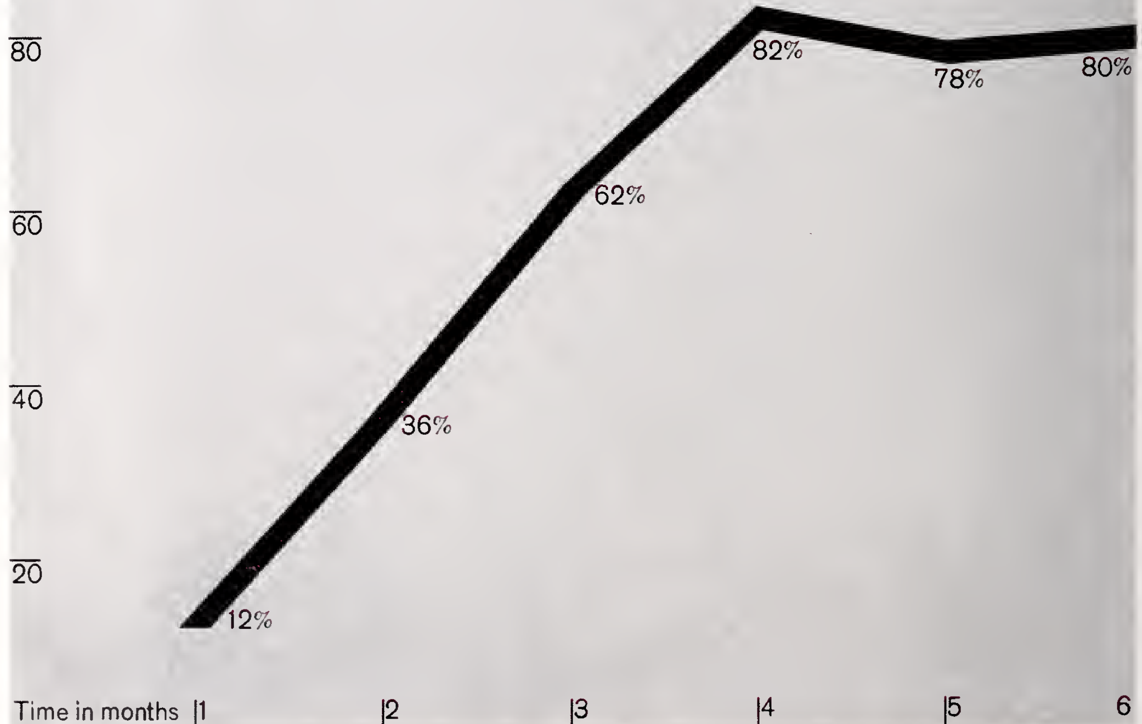
Persantin® brand of dipyridamole, 25 mg. t.i.d. or q.i.d., was administered continuously for 6 months to 50 patients with well authenticated ischemic heart disease with angina pectoris and ECG abnormalities. Results were evaluated on a monthly basis; final evaluation after 6 months showed that 56% of patients were completely free of, or had markedly fewer, anginal attacks, with normal or improved ECG findings; an additional 24% experienced fewer, milder attacks and improved work capacity.

Persantin®
brand of dipyridamole

"...long-term oral therapy with dipyridamole was of benefit in 80 per cent of the patients... relief [of angina] came slowly and was usually maximal after three to six months of continuous treatment"

% of patients responding each month to dipyridamole

Steady, month-by-month improvement with Persantin® brand of dipyridamole, refutes possibility of "placebo response", reflects gradual improvement in underlying pathology.



Study 2.
Wirecki,M.: Dipyridamole (Persantin®): Evaluation of Long-Term Therapy in Angina Pectoris. Current Therapeutic Research 5:472, 1963.

In 40 ambulatory patients with myocardial ischemia, angina pectoris, and abnormal ECG findings, Persantin® brand of dipyridamole, 25 mg. t.i.d., was administered continuously for 3 months.

Results after 3 months of therapy revealed a satisfactory clinical response in 32 patients. The accompanying diagram illustrates the specific criteria of improvement in patients with excellent or good response.

Of 40 patients, 32 showed "...reduction or abolition of acute anginal attacks...complete or almost complete disappearance of ECG abnormalities... marked increase" in walking distance without anginal symptoms

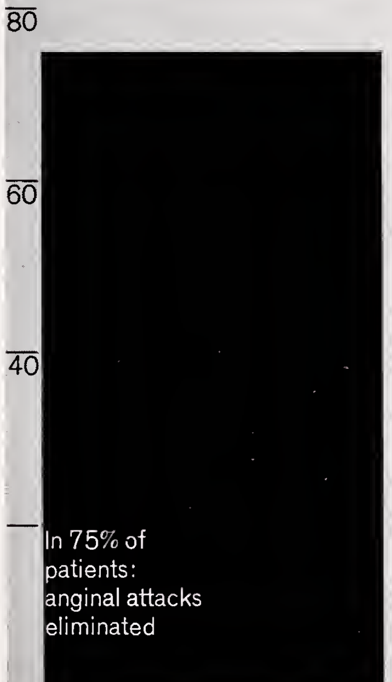
Response after 3 months of continuous therapy with Persantin® brand of dipyridamole

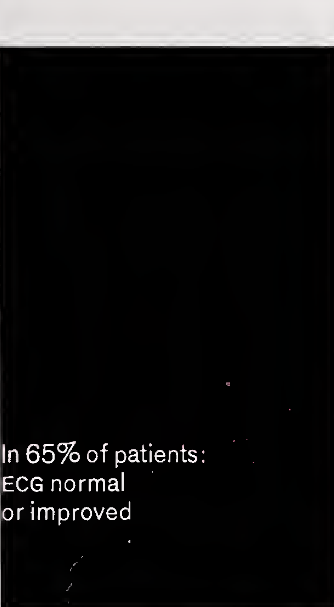
% of patients

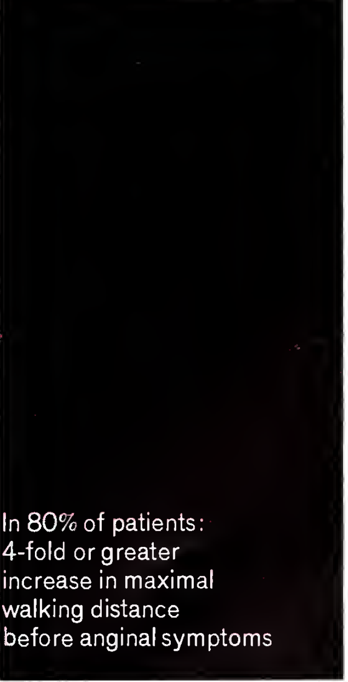
80

60

40







How Persantin,® brand of dipyridamole, provides long-term clinical benefits reported on previous pages

1. By increasing energy yield
of the hypoxic myocardial cell, by direct action upon the sarcosomes (heart mitochondria).[1-5]

2. By improving collateral coronary circulation.
Prolonged oral administration of dipyridamole to animals with experimentally induced stenosis of a major coronary artery resulted in superior development of collateral coronary anastomoses and longer survival compared with controls.[6-9]

When given for prolonged periods and in adequate dosage, dipyridamole improves the coronary flow deficit of the ischemic myocardium while supporting cardiac metabolism during the period of repair. Clinically, this is manifested as steady improvement – anginal attacks diminish in frequency and intensity, as do other manifestations of insufficiency (dyspnea, fatigue, and, in many instances, abnormal electrocardiographic findings).

Availability:
Tablets of 25 mg., bottles of 100 and 1000.
Under license from Boehringer Ingelheim G.m.b.H.

Prescribing summary: Persantin,® brand of dipyridamole, is indicated in coronary and myocardial insufficiency, in a dosage of 2 to 6 tablets daily in divided doses before meals for several weeks. Side effects (headache, dizziness, nausea, flushing, weakness, syncope, mild gastrointestinal distress) are minimal and transient. The drug is not recommended in the acute phase of myocardial infarction, and should be used cautiously in hypotension.

References: 1.Kunz,W.;Schmid,W.,and Siess,M.: Arzneimittel-Forsch.12:1098,1962. 2.Siess,M.: Arzneimittel-Forsch.12:683,1962. 3.Laudahn,G.: Experientia 17:415,1961. 4.Lamprecht,W.: 27th Congress of the German Society for Circulation Research,Bad Nauheim,1961. 5.Hockerts,T.,and Bögelmann,G.: Arzneimittel-Forsch.9:47,1959. 6.Vineberg,A.M.,et al.: Canad.M.A.J.87:336,1962. 7.Chari,S.R.et al.: Presented at the International Congress of Chest Physicians,New Delhi,1963. 8.Neuhaus,G.,et al.: Presented at the Fourth World Congress of Cardiology,Mexico City,1962. 9.Asada, S.,et al.: Japanese Circ.J.27:849,1962.

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Ardsley, New York, Distributors

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THE INSURANCE PAGE

Voluntary Health Prepayment . . . . . Real Protection Or Token Protection?

ACCORDING to figures quoted recently in the AMA News, approximately 84% of our population are protected against part or all of their health care costs through voluntary prepayment mechanisms.

The question is often raised as to the *degree* of protection which is provided by voluntary health insurance and prepayment. Proponents of compulsory insurance under governmental supervision claim that coverage available through the voluntary organizations is, by and large, inadequate.

Statistical measurement of the extent of such coverage obviously has certain limitations, depending on the range of services which may feasibly be included under insurance, and on the extent to which subscribers may wish to prepay for their total health care needs.

Most subscribers, apparently, believe that health insurance should meet only those expenses which would be burdensome, and that the inclusion of occasional home or office visits by physicians, and of such items as prescriptions for drugs is wasteful, inefficient, and unnecessary. To state it in another way, insurance against such costs is merely "swapping dollars." Others, however, seem to feel that all physicians services in home, office, or hospitals; dental care, drugs, etc. should be covered.

According to a survey made by the Health Insurance Foundation in 1958, if all of the benefits paid out by all prepayment organizations were divided by the expenditures for the total medical care furnished to all persons (insured and uninsured) less than 20% of the total health care costs of our people was being provided through voluntary health insurance. It should be recognized, however, that the above figures include the cost of custodial care, as well as expenditures for optional and luxury items; and that those services furnished through charitable organizations and governmental facilities were also listed.

A more realistic method of determining the adequacy of protection is to study a large group of people who incurred charges on those items for which they were insured, and to divide the benefits paid out for those items by the expenditures for them. On this basis, the survey quoted above showed that at least half of the insured families were more than 88% covered for their hospital expenses, and 81% covered for their surgical expenses. In some cases, practically 100% of the hospital and physicians charges are being taken care of through prepayment coverage. This is especially true of many Blue Cross and Blue Shield subscribers.

The indigent and medically indigent portion of our population will continue to depend on charity or on public funds for their health needs in the future, as they have in the past.

For the rest of our people, it has been proven that adequate health care can be financed through voluntary prepayment.

It would be a foolish and tragic mistake to substitute a compulsory national health service (with its rigid and costly beaurocratic controls) for the marvelously flexible systems which have developed under our free enterprise way of life, and which with each passing year are becoming more efficient and comprehensive.

W. VINSON PIERCE, M.D.

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BRIEF SUMMARY: *Indications:* Anxiety and tension states, and all conditions in which anxiety and tension are symptoms. *Side Effects:* Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1-4 doses of the drug. *Contraindications:* Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. *Precautions:* Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities, to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available to physicians on request.*

USUAL ADULT DOSAGE: 1 or 2 400 mg. tablets t.i.d.

SUPPLIED: 400 mg. scored tablets, 200 mg. coated tablets.

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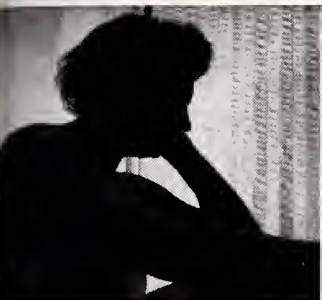
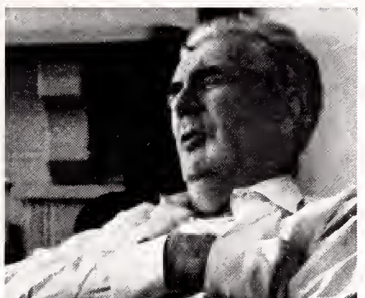

The insomniac

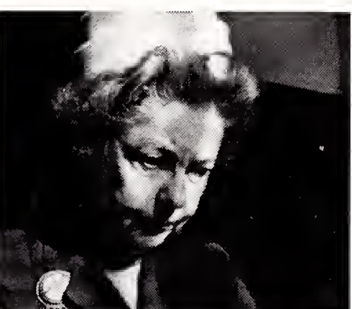
The tense, nervous patient

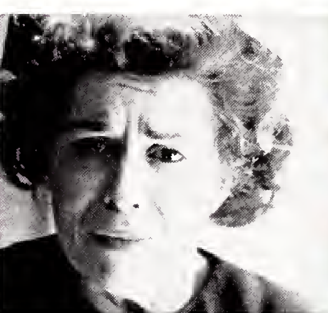

The heart-disease patient

The surgical patient

The girl with dermatosis

Tension headache

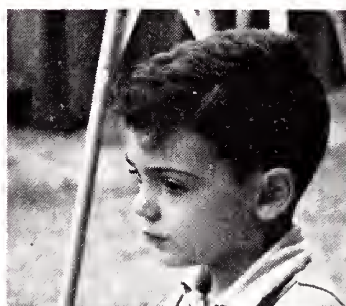

The woman in menopause


Anxious depression

Premenstrual tension

The agitated senile patient

The alcoholic


The problem child

The G.I. patient

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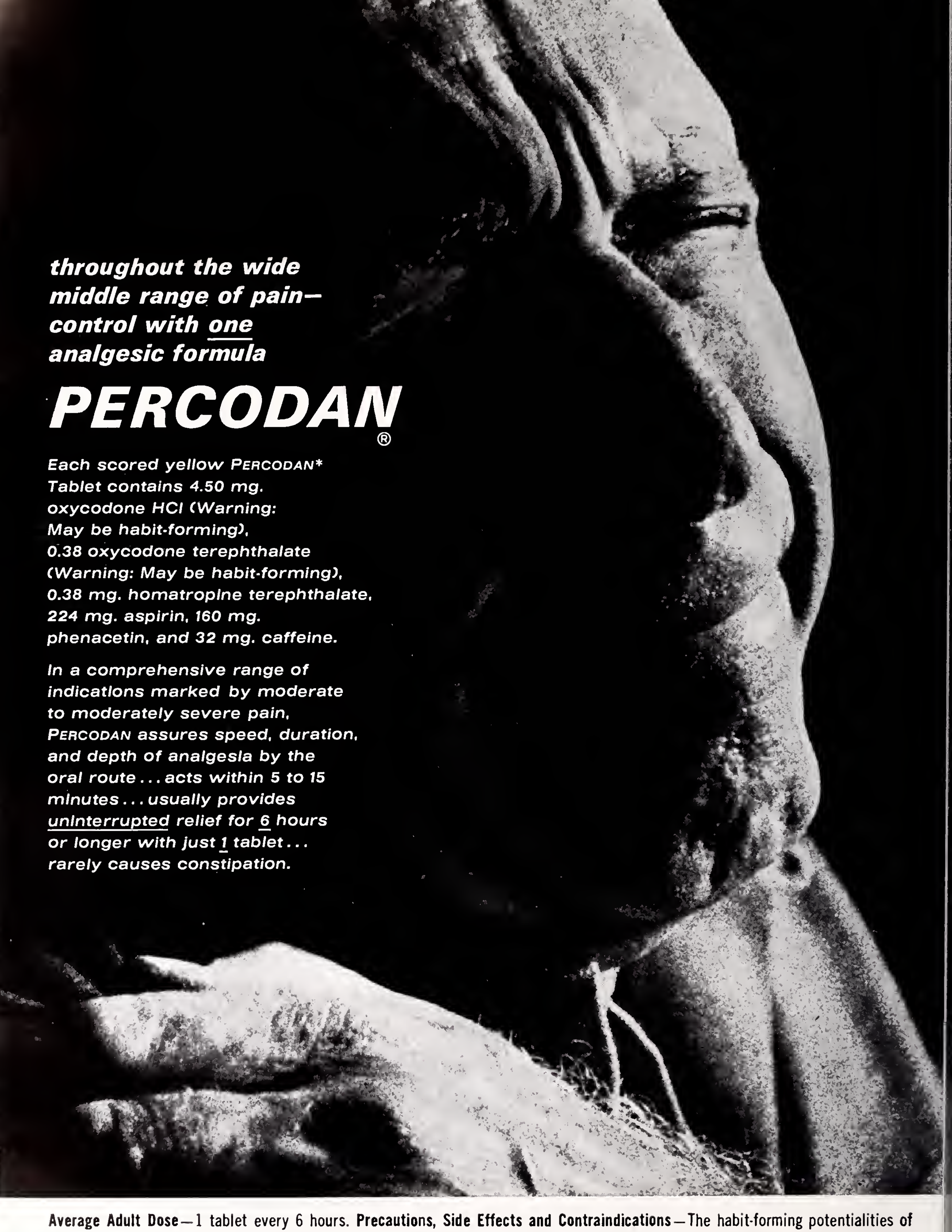

Average Adult Dose—1 tablet every 6 hours. **Precautions, Side Effects and Contraindications**—The habit-forming potentialities of Percodan are somewhat less than those of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although generally well tolerated, Percodan may cause nausea, emesis, or constipation in some patients. Percodan should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. **Also available:** Percodan®-Demi, containing the complete Percodan formula but with only half the amount of salts of oxycodone and homatropine. Both products are on oral Rx in all states where laws permit. Narcotic order required. **Literature on request.** **ENDO LABORATORIES Richmond Hill 18, New York**

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Average Dose: 1 to 2 tablets (or capsules) 3 times a day. 1 teaspoonful elixir 3 times a day.

Formula: Each tablet or capsule contains:
Pentylenetetrazol............. 100 mg.
Nicotinic Acid................. 50 mg.
Each teaspoonful (5 cc.) elixir contains:
Pentylenetetrazol............. 200 mg.
Nicotinic Acid................ 100 mg.
(as the sodium salt)
Alcohol......................... 5%

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NICOZOL®

PUBLIC HEALTH PAGE

Syphilis, The Omnipresent Disease*

Russell E. Teague, M.D., M.P.H.
Commissioner of Health—Commonwealth of Kentucky

SYPHILIS is a disease often called man's greatest plague. Indeed we were all ready to accept this concept a few years ago. Now, however, we have the knowledge, skills, and medicine which should enable us to eradicate the disease, but alas, it is still with us and on more than a modest increase.

A physician in private practice has the major role in the eradication of this costly disease. To fulfill this role, he is urged to better acquaint himself with the fact that syphilis has been increasing at an alarming rate since 1957, and that this increase has been evidenced in all segments of the population, in all economic and social groups, in all races, in both sexes, and in all age groups. Particularly alarming has been the increase among persons under the age of 25 and especially the teenager.

The private practitioner needs also to be aware of the marked increase in the number of persons with infectious syphilis who are involved in homosexual activity. Physicians have underestimated the possibility of a private patient being infected through homosexual practice, and when he has recognized the case of the homosexual's syphilitic infection, he has been understandably reluctant to report the case to the health department because he is not sure that the patient's anonymity would be safeguarded.

Physicians must realize the serious responsibility taken upon their shoulders when they fail to report any serious communicable disease, especially syphilis, and that while they may well be protecting the temporary embarrassment of their private patient, they may at the same time be aiding and abetting the continued spread of infection to an unsuspecting public. The private physician in reporting diagnosed cases of infectious syphilis to the proper health authorities aids in the protection of the patient as well as the community from further spread of the disease.

The control and eradication of syphilis must necessarily combine medical diagnosis and treatment with a means of locating and bringing possible infections to medical attention. It is for this reason that the Kentucky State Department of Health, in cooperation with the U. S. Public Health Service, staffs its Venereal Disease Control Program with a paramedical group of thoroughly trained, professionally competent persons who perform the necessary epidemiological duties to get suspected cases under the proper medical supervision. The private physician who properly reports a case of infectious syphilis and accepts the epidemiological service of the State Department of Health is assured that the venereal disease field epidemiologists understands and respects the physician-patient relationship and the confidential nature of their work.

During fiscal year 1963, Kentucky's private practitioners reported 49 or 35.5% of the 138 cases of primary and secondary syphilis reported to the State Department of Health. The physicians reporting these cases utilized the epidemiologic assistance of a trained field epidemiologist provided by the State in all but one of the cases reported.

As a result of applying intensive epidemiologic measures to the 48 cases, the venereal disease worker was able to obtain, through interviews, 177 sex contacts (a contact index of 3.69); identify 59 persons who were presently or previously infected with syphilis; and bring 24 persons to treatment for syphilis, 20 of which were in an infectious stage. From these 20 lesion cases, ten additional infectious cases were found and placed under medical supervision and subsequent treatment.

In a recent questionnaire survey conducted by the American Social Health Association with the cooperation of the AMA, the American Osteopathic Association, and the National Medical Association, 1,506 Kentucky physicians responded, with 70 stating that they had treated 105 cases of infectious syphilis during the three-month study period. Records of the State Department of Health showed that only seven cases or 6.7 per cent had been reported.

Even if 50% of all cases diagnosed during the last fiscal year were reported, there would remain 49 infectious cases unreported. By applying the same indices that were obtained from private cases reported last year, the field epidemiologist could have obtained 362 sex contacts, identified 118 persons with past or present syphilitic infection, brought 48 persons to treatment, and found 40 with syphilis in an untreated primary or secondary stage.

As long as this unreported, uninvestigated reservoir of infectious cases remains within the population, not only will eradication be impossible, but simple control will not be obtained.

The eradication of syphilis as a public health problem is a most worthwhile goal, but it cannot be realized without the cooperative effort of private medicine and public health.

**This article was prepared with the assistance of Pete Campassi, Jr., Public Health Advisor, U. S. Public Health Service, Venereal Disease Control Program, Kentucky State Department of Health, 275 East Main Street, Frankfort, Kentucky.*

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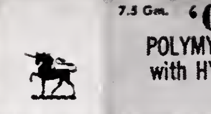

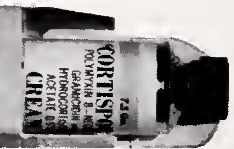

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a special low melting point base

anti-inflammatory
bactericidal
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rarely sensitizing

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In a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, distilled water, and 0.25% methylparaben as preservative.

Available: In tubes of 7.5 Grams.

OINTMENT—*Ingredients:* Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 5,000 Units; Zinc Bacitracin 500 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base); Hydrocortisone 10 mg. (1%).

In a special white petrolatum base.

Available: In tubes of ½ oz. and ⅛ oz.

*U. S. Patent Nos. 2,565,057–2,695,261

Indications: Wherever inflammation or infection occurs and is accessible for topical therapy.

Contraindications: These drugs are contraindicated in tuberculous, fungal or viral lesions (herpes simplex, vaccinia and varicella).

Caution: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

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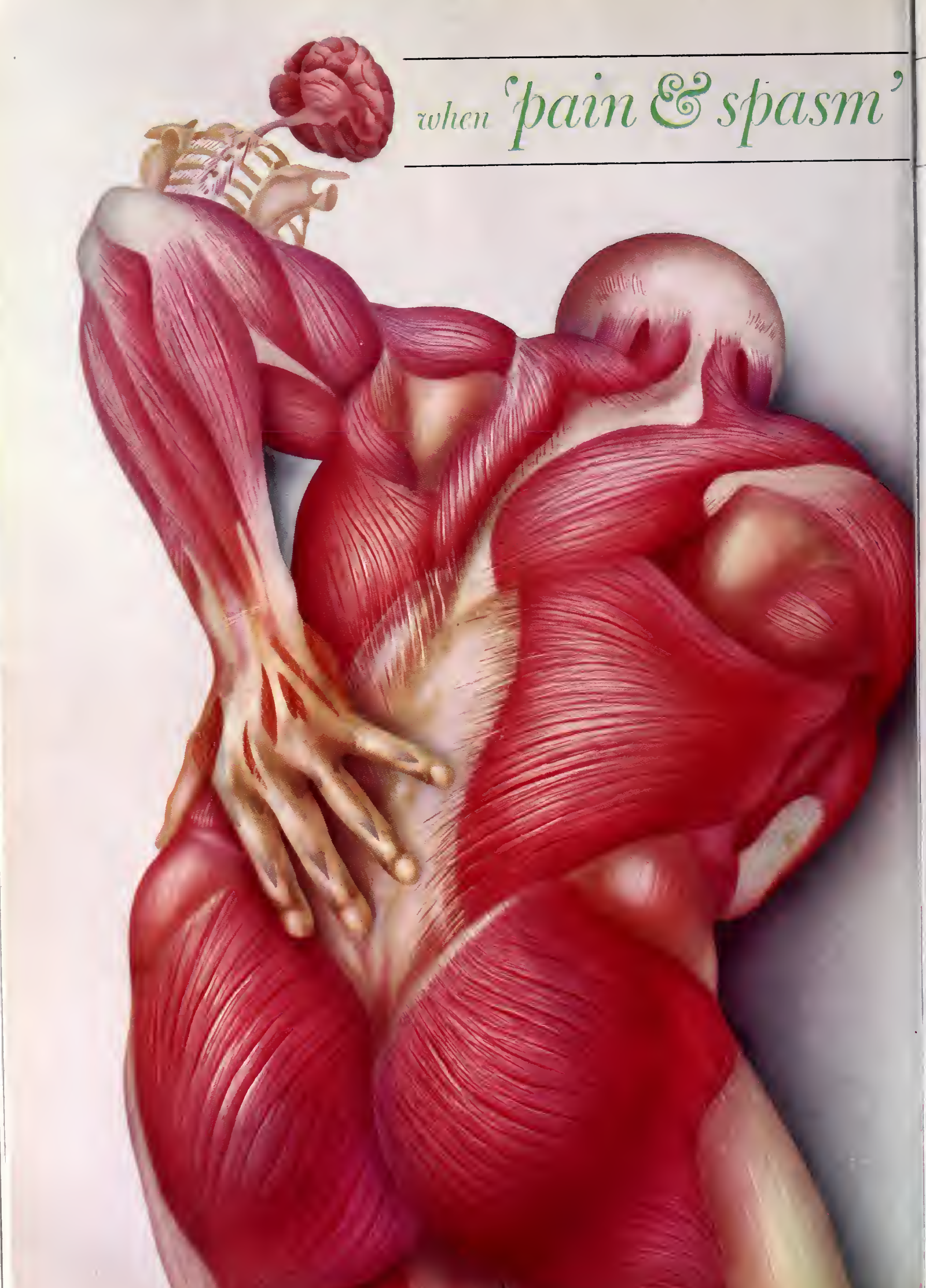
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*Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961.

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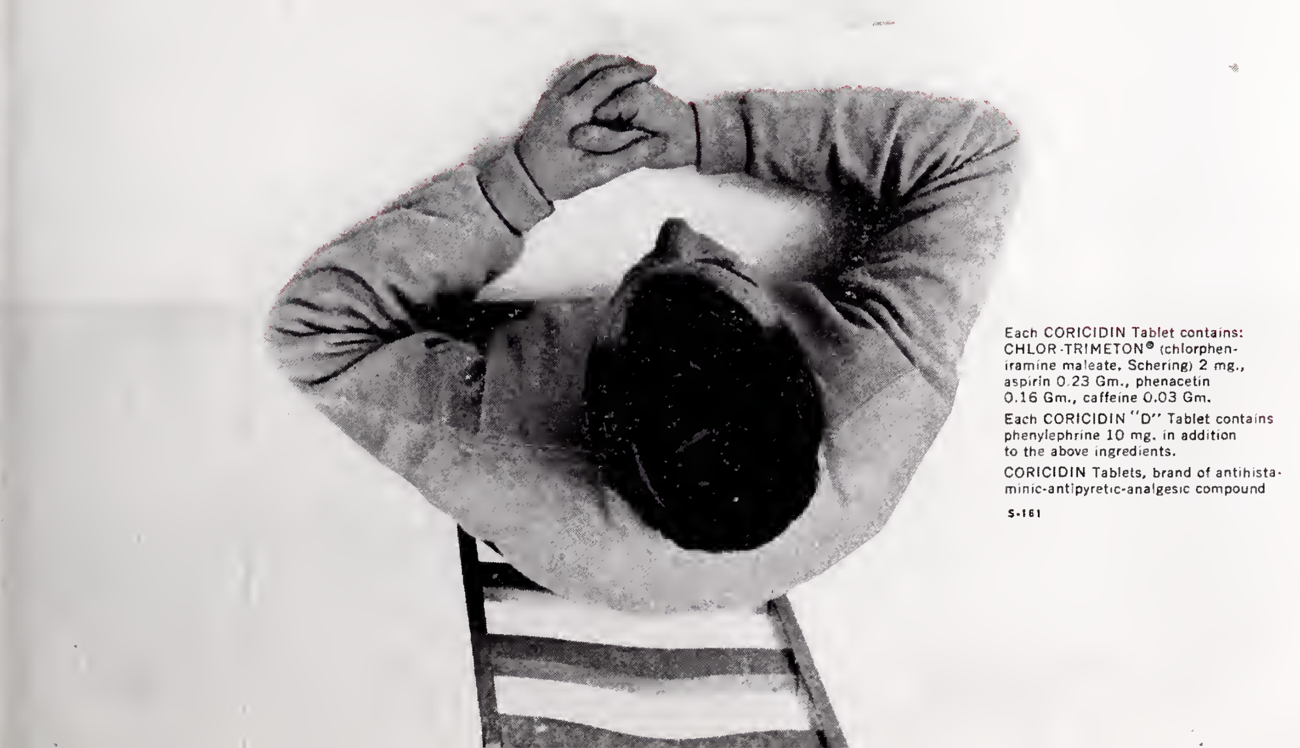

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VOLUME 61 OCTOBER, 1963 No. 10

Symposium on Endocrinology*

AS SYMPOSIUM Editor it is my pleasure to present four reviews which bring up to date certain important aspects of clinical endocrinology. The authors have achieved an excellent correlation between basic principles and bedside medicine which emphasizes the rapidly increasing importance of objective techniques in the recognition and understanding of endocrine disorders.

The clinician who deals with such problems is deeply indebted to the investigator for many significant discoveries of recent years. The application of cytogenetic technics is among the most recent to shed new light upon the basic chromosomal aberration in two familiar types of gonadal dysgenesis: Klinefelter's syndrome in the male and Turner's syndrome in the female. Although it is unlikely that other diseases will show such easily recognized abnormalities it is quite clear that genetic factors play a prominent role in the pathogenesis of certain disorders of the thyroid and adrenals as well as of diabetes mellitus.

Endocrine research has long been concerned with the precise identification of a particular hormone and the effort has been very productive. Many outstanding examples exist, among which are: elucidation of the structure of insulin and certain adenohypophyseal hormones; the isolation, identification and synthesis of vasopressin; the identification of epinephrine, thyroxine, triiodothyronine, cortisol, aldosterone and the sex steroids.

Rapid advances characteristically follow the identification of a specific hormone and inevitably these influence clinical thinking as well as research design. For example, every experienced clinician is aware that thyroid disorders can be detected with much greater precision than equally important parathyroid disease. This is largely due to the availability of technics of high precision which measure the thyroidal metabolsim of iodine and the concentration of thyroid hormone in the serum. On the other hand parathyroid function can only be estimated indirectly and entirely unrelated disorders may closely simulate the effects of parathyroid hormone upon the metabolism of bone, the serum concentration of calcium and phosphate and the renal excretion of these substances. Clearly needed is a technique which will permit the direct measurement of parathyroid hormone concentration in body fluids. Rasmussen's studies on the isolation and identification of parathyroid hormone represent major progress in this direction but the ability of the usual clinical laboratory to measure parathyroid hormone still seems quite remote.

Investigators have recently become aware of factors which influence the transport of hormones in the blood and have begun to recognize the importance of the plasma proteins in an amazingly complex and dynamic system. The importance of thyroxine-binding globulin (TBG) is clearly presented in this Symposium. The measurement of free thyroxine in human

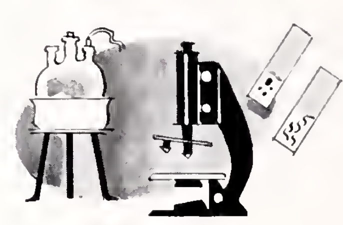
*This special symposium was prepared under the direction of Symposium Editor Beverly T. Towery, M.D., Chairman of the Department of Medicine at the University of Louisville School of Medicine, Louisville, Ky.

serum has been reported recently.[1] This represents a significant technical achievement since the normal concentration of free thyroxine was found to be only 1.3×10^{-10} M/L!

In this connection it is intriguing to consider the situation during late pregnancy in which thyroxine synthesis occurs in the fetal as well as the maternal thyroid. Free thyroxine is believed to cross the placenta readily whereas TBG does not. The ultimate distribution of thyroxine between mother and fetus would depend, therefore, upon the competition between maternal and fetal TBG. Theoretically a severe deficiency of TBG in the fetus would permit the rapid loss of thyroxine into the maternal circulation and lead to severe hypothyroidism and compensatory goiter in the child. This is merely an hypothesis but constitutes a fertile field for future investigations.

Beverly T. Towery, M.D.

[1] *Sterling, K. and A. Hegedus. J. Clin. Invest. 41*:1031, 1962.



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Chromosomes and Clinical Practice

James W. Rackley, M.D.,* and Joyce M. Noonan**
Lexington, Ky.

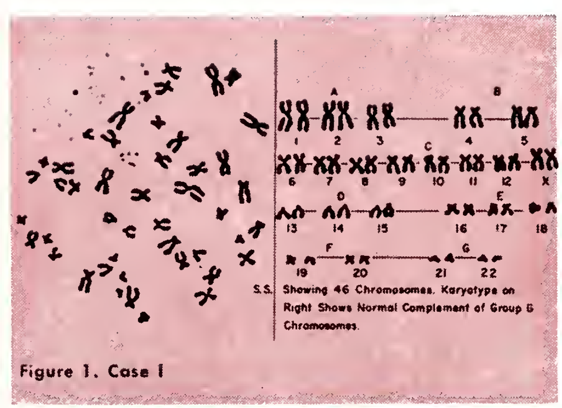
In the past several years a whole new field of medicine has been developed called "Human Cytogenetics." This field received its first impetus from the discovery by Barr and Bertram in 1950 of the sex chromatin body.[1] Later Tjio and Levan in 1956 showed that the diploid number of chromosomes in the human is 46 rather than the 48 which had been believed for so many years.[2] These findings were quickly confirmed by others and reports began to appear of abnormalities in the human chromosomal complement associated with various diseases and syndromes. The clinician faced with these reports has been forced to learn or relearn a new vocabulary of terms. At first these reports may have seemed to have only academic interest. However, as knowledge has increased of the mechanisms involved, these findings have become of much more practical interest and application. To illustrate the clinical applications, we present the following two cases.

Case I

S. S., a six-year-old white female presented for a preschool examination. At birth following an uncomplicated pregnancy, labor, and delivery, the mother had been told that the child possibly was mongoloid. Subsequently, at six weeks of age the attending physician had ruled out this possibility. Later during childhood, other physicians had given conflicting opinions as to the presence or absence of mongolism.

Developmental History. She sat alone at nine months, stood alone at fourteen to fifteen months, and walked unassisted at seventeen to nineteen months. Speech began between two and two-and-one-half years of age. She spoke simple sentences at three and one half years of age.

Family History. Three siblings are living, well, and in good health with no suggestion of mongolism or developmental retardation. The mother was twenty-five years of age at the time of the patient's birth. Physical examination revealed a well-developed, well-nourished, white female child of normal height and weight. There were bilateral epicanthal folds, Brushfield spots, a high, arched palate, and short fifth fingers. There were no simian lines. There was no separation of the first and second toes. She was seen by three separate experienced physicians who each felt that she probably was mongoloid, but they were not certain. Hand and foot prints were suggestive but not diagnostic of mongolism. Psychometric studies using the Wexler Intelligence Scale for Children revealed a verbal IQ of 65 and a performance IQ of 95 yielding a Full-Scale estimate of 75.



Showing 46 Chromosomes. Karyotype on Right Shows Normal Complement of Group G Chromosomes.

Figure 1. Case I

Chromosomal studies were performed on the peripheral blood by the method of Moorhead, et. al.,[3] with the following results: 52 cells were counted, one contained 43 chromosomes, one contained 45 chromosomes, 32 cells contained 46 chromosomes, and 18 cells contained 47 chromosomes. Thirty-three of these cells were suitable for detailed analysis. Twenty contained a normal complement of 46 chromosomes with 44 autosomes plus XX. Thirteen cells contained 47 chromosomes with trisomy of number 21 (See Figures 1 and 2).

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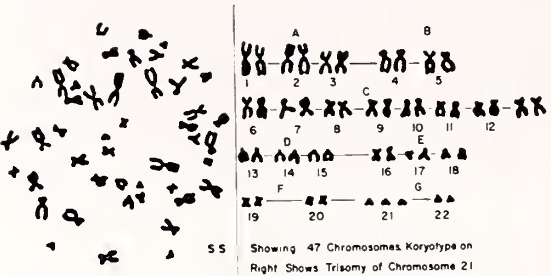

Figure 2. Case I

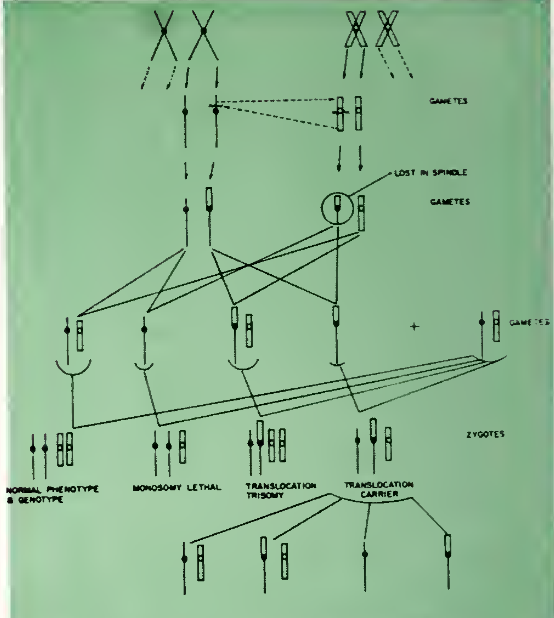

Figure 3. Diagram of the mechanism of translocation and it's transmission to subsequent generations.

Comment

Mongolism—the well-known syndrome which includes mental retardation, epicanthal folds, high-arched palate, short incurved fifth fingers, simian lines, wide-spaced first and second toes and other anomalies — is usually caused by trisomy of chromosome number 21. This was first described by Lejeune, et. al., in 1959.[4] Mongolism occurs most commonly late in the childbearing period. The mean maternal age at the birth of the mongoloid child is 37 compared to a control age for all births of 29.[5] Nondisjunction during gametogenesis, which in most cases is of maternal origin, is the causative mechanism of trisomy. Mongolism can be familial and in many of these cases the mechanism is translocation.[6, 7] (See Figure 3). The carrier demonstrates 45 chromosomes with a missing chromosome of group 13-15, a missing chromosome number 21 and an "extra" chromosome which seems to fall into group 6-12 plus X. The mongoloid child of such a carrier demonstrates 46 chromosomes with a missing chromosome of group 13-15 and an "extra" chromosome in the group 6-12 plus X.[8] Since the "extra" chromosome is actually a translocation containing the long arms of the "missing" 13-15 and long arms of a number 21, functionally there is trisomy of number 21. Other variations which have been found are iso-chromosomes and translocations to chromosomes of other than the 13-15 group.[9] (See Figure 4).

Perhaps the greatest practical application of chromosomal studies is the case of a mongoloid child of a young mother, particularly the mongoloid child with a family history of mongolism. Most such children on chromosomal analysis will be the usual trisomy 21. In such cases one can counsel the parents that there is only slightly greater chance than random selection that subsequent children would be mongoloid. If translocation is found and the mother is found to be a carrier, one can advise her that each subsequent child has a 20-35 per cent chance of being mongoloid. Most authorities would now agree that all mongoloid children born of young mothers should have chromosomal studies if possible.

Case I illustrates two facets of this problem. The case is suggestive but not typical of mongolism, and the mother is young and still in the childbearing age. Following chromosomal studies diagnosis was established of mosaic mongolism. The mother was reassured that the risk of subsequent children having mongolism was no greater than random chance.

Mosaicism is most commonly caused by nondisjunction after fertilization. It results in two or more karyotypes in the tissues of the individual.

Case II*

**This case is presented by the courtesy of Phillip Crossen, M.D., and Edward H. Ray, Jr., M.D.*

R. D. H., BD: 9/28/54, was first admitted to the University Hospital, University of Kentucky Medical Center, on 10/9/62 with a 24-hour history of vomiting. Past history and review of hospital records from previous hospitalizations at another hospital revealed the following data. After an uncomplicated antenatal course, the patient was delivered spontaneously of a gravida 2, para 1 mother. Birth weight was 4 pounds 13 ounces. The sex was indeterminate in that it was originally written

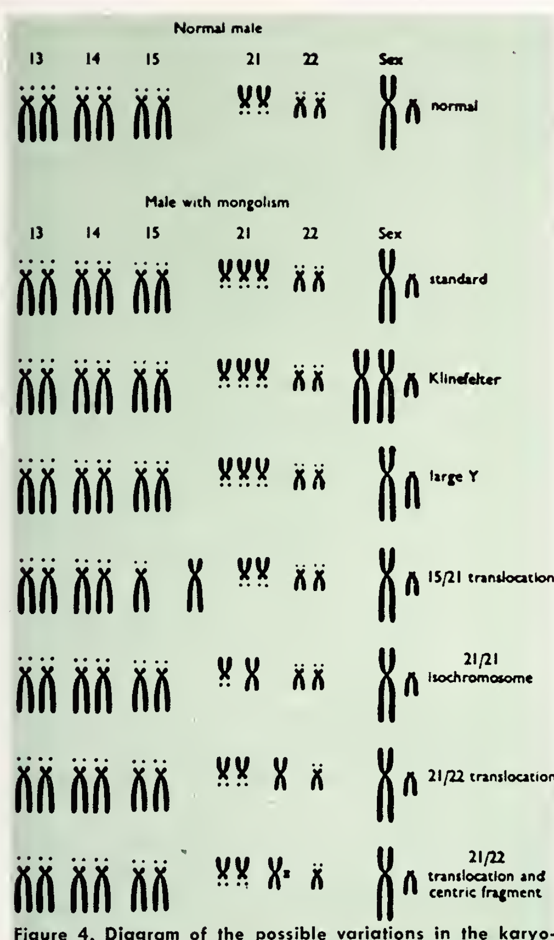

Figure 4. Diagram of the possible variations in the karyotype of mongolism.

down as a girl then changed to boy. Diagnosis on discharge at 10 days of age was pseudohermaphroditism, sex indeterminate. He was seen at this time by a consulting physician who found a phallus with chordee, a urethral opening at the base of the phallus and behind the urethral opening what appeared to be a tiny vaginal opening. The recommendation was made that the child have a laparotomy in six to eight months for sex determination.

The parents failed to follow up on this recommendation, and the child was apparently lost to medical supervision until the age of seven years. At this time he began the first grade and was sent home after two weeks with the recommendation by the school that "something be done about his genitalia." He had been raised as a male.

As an outpatient, urinary 17-ketosteroids were less than 1 mg per 24 hours. Sex chromatin was negative. Psychological testing revealed an IQ of 61 with male identification. In March, 1962, laparotomy was done. The findings at laparotomy were a small uterus measuring 1.0 x 0.5 cm and fallopian tubes bilaterally. There was a gonad on one side only which was removed and was shown microscopically to be immature testis. At the same operation, lysis of the chordee was performed.

Physical examination at the time of admission to the University Hospital revealed a small, thin, slightly dehydrated boy with a horizontal scar on the lower abdomen from the previous laparotomy. Positive physical findings are limited to the genitalia. (See Figure 5).

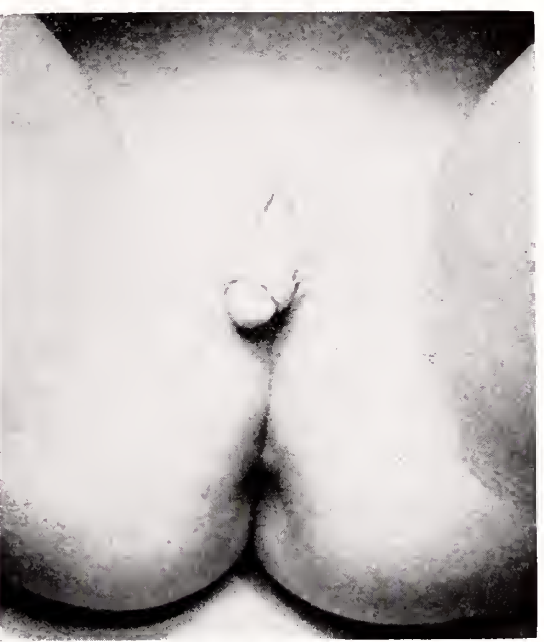

Figure 5. Case. II. Photograph of the external genitalia.

Analysis of the chromosomes from leukocytes of the peripheral blood was performed. Thirty-eight cells were counted and 17 analyzed. Eight cells analyzed contained 46 chromosomes with 44 autosomes plus XY. Nine cells analyzed contained 45 chromosomes with 44 autosomes plus XO.

Comment

Case II illustrates the problems that one encounters in the study of patients with indeterminate sex. Bergada, et. al.,[10] recently compiled the data on 12 cases, including 2 from the literature, of asymmetrical gonadal differentiation. These cases invariably had a uterus, one gonad which was testis; and either no gonad on the opposite side, or a streak, or a small embryonic gonad. External genitalia was either

male or ambiguous in every case. Undoubtedly, it would have been more practical if this child early in infancy had been designated as a female, since plastic surgery for construction of an adequate vagina for normal function is technically much easier. The patient will never be able to function sexually as a male. This case illustrates very well the importance of pursuing these studies in infancy. It also illustrates the principle of not attempting to change sex later in life. Psychological tests demonstrated that the child had definitely identified as a male, and it was felt that any attempt to change sex at this age would only create problems. Thus it was entirely proper and correct to remove the internal genitalia at the time of surgery. Subsequent surgery remains to be done with the closing of the perineal opening and construction of a penile urethra.

Comment

The practical application of chromosomal studies for the clinician in private practice would appear to lie in four areas: (1) problems of sex determination. (2) Problems of mental retardation, sterility, or menstrual irregularity. (3) Problems with genetic counseling. (4) Search for new disease entities.

(1) *Problems of sex determination.* Patients with ambiguous genitalia or indeterminate sex present a most challenging problem to the physician. The goal of diagnosis and treatment is an individual of normal appearance, normal function including sexual function, and normal emotional adjustment. It is a well-recognized fact that sex determination must be final by a relatively early age to prevent emotional maladjustment. Rational diagnosis and therapy, in addition to the usual history, physical examination, and endocrine studies, often requires determination of the sex chromatin, analysis of the chromosomes, and gonadal biopsy. Although from a practical standpoint, one must choose the treatment program most likely to result in relatively normal function and appearance; one must not neglect every possible help in reaching a decision.

(2) *Problems of mental retardation, sterility, and menstrual irregularities.* In the work up of patients with such problems individuals with chromosomal abnormalities will represent only a small percentage of the total. It must be remembered, however, that quite commonly a patient with one of the above mentioned complaints does not have all the signs and symptoms of the "textbook" syndrome. For example, a man may present for work up of sterility who has normal appearance, normal intelligence, and small testes, and with chromosomal studies have Klinefelter's Syndrome. Or a young woman might have primary amenorrhea, failure of development of secondary sex characteristics and no other anomalies but whose chromosomal analysis might demonstrate Turner's Syndrome with 44 XO. For abnormalities of the sex chromosomes a carefully performed buccal smear for determination of sex chromatin is a very useful and relatively inexpensive screening test.

(3) *Genetic counseling.* Invariably the parents of the child with congenital anomalies ask the two questions, "What caused it?" and "If I have other children, will it recur?" Whether consciously or unconsciously, verbally or to themselves, these questions always occur. All too often, the physician in attendance cannot answer these questions. Now, however, in the case of the syndromes discussed above and others beyond the scope of this discussion, we can answer the question "What caused it?"; although the more basic question of "What caused the nondisjunction or the translocation?" remains unanswered. In some cases we can even answer the question "What are the chances of the same thing happening in subsequent children " As a generalization, one can say that if nondisjunction has occurred during meiosis the chances are slightly greater than random selection of this occurring again. If nondisjunction has occurred during a mitotic division, as in Case I presented above, the chances are probably no greater than random of subsequent occurrence.

(4) *Search for new disease entities.* Theoretically there should be an autosomal trisomy syndrome for each of the 22 pairs of autosomes. It would appear, however, that such is not the case and that trisomy for many of the autosomes is lethal in embryonic life. Nevertheless, many congenital anomalies must occur because of chromosome abnormalities, especially partial trisomy, insertions, and translocations; and when these occur, especially on a familial basis, we must continue to study and search for the increase of our knowledge.

(Continued on Page 893)

Evaluation of Laboratory and Radiologic Techniques In The Diagnosis of Thyroid Disease

GERALD M. PETERSON, M.D.* AND MALCOLM L. BARNES, M.D.**
Louisville, Ky.

Introduction

IN RECENT years the established thyroid function tests have been joined by many new—as well as modifications of the old—laboratory and radiological procedures. The study of a patient with dysfunction of the thyroid may become confusing to the physician and costly to the patient. In the final analysis the diagnosis rests upon the physician's correlation of history, physical findings, and laboratory data. Generally accepted diagnostic procedures include the BMR, the serum protein-bound iodine and cholesterol concentrations. The newer procedures are based upon the use of radioactive iodine in estimating the rate of uptake of iodine by the thyroid, its incorporation into thyroid hormone, the release of the hormone into the blood stream, its transport to the "peripheral" cells of the body and finally its utilization in maintaining metabolic processes.

Relation of Iodine to Synthesis and Transport of Thyroid Hormones

In areas of adequate iodine supply, the normal adult ingests about 150 micrograms of iodine daily and excretes a similar amount, thus remaining in iodine balance. Iodine must be converted to iodide before it can be absorbed, after which it is distributed throughout the body fluids to constitute the "iodide pool." In the average person this amounts to about 75 micrograms of iodide. (The iodide "pool" or "space" is approximately twice the extracellular fluid volume or about 35% of body weight. —Ed.) Much of this iodide circulates in the blood and is available to the kidneys, the thyroid gland, the salivary glands, the sweat glands, and the mammary glands. Most of the turnover of iodide, however, occurs through the action of the thyroid or the kidneys. The thyroid gland has the ability to concentrate iodide in relatively large quantities. This provides the basis of some important indices of thyroid function. Using radioactive iodide, the percentage uptake of a given tracer dose can be estimated after a standard interval as a measure of the relative functional status of the gland.

Once the iodide enters the thyroid it is promptly bound in "organic" form to establish a thyroidal "pool" which amounts to a total of about 8 mg. of iodine. An additional amount of iodine circulates as thyroid hormone and forms another pool estimated to average 1.2 mg.

The thyroid epithelial cells oxidize and finally convert iodide ions to thyroxine which may be released into the blood or converted to thyroglobulin and stored in the thyroid for subsequent release. Probably a small amount of triiodothyronine is formed in the thyroid and rapidly released for the use of the body tissues.

Electrophoretic studies of plasma reveal that thyroxine is preferentially bound to the $alpha_1$ and $alpha_2$ globulins (thyroxine-binding globulin, TBG) whereas triiodothyronine is poorly bound. In addition some thyroxine is carried by the plasma albumin. Owing to the high efficiency of protein-binding only a very small fraction of the total plasma thyroxine exists in the free state but it is believed that this moiety regulates the pituitary secretion of thyrotropin and is directly responsible for the effects of thyroid hormone upon cellular metabolism. According to this hypothesis thyroxine must be released from its protein companion in order to gain access to the cell.

If this assumption is accepted it becomes readily apparent that the concentration of free thyroxine depends upon the concentration of

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TBG as well as upon the rate of thyroxine synthesis and release by the thyroid. If the concentration of TBG were increased augmentation of thyroid function would be necessary to maintain a normal "thyrometabolic" status. Under such circumstances the bound thyroxine would be reflected in a rise in the total protein-bound iodine (PBI) concentration while the free thyroxine and the metabolic status remained within normal limits. This is presumably the state in normal pregnancy in which abnormally high concentrations of PBI are found in women who are essentially euthyroid by all other criteria.

Although the PBI provides a reliable measure of the concentration of bound thyroxine in the plasma the measurement of free thyroxine is not practical. However, the extent to which added thyroxine can be bound provides some evidence as to the relative proportions of free thyroxine and TBG. This is discussed in more detail later in connection with the T_3*-uptake test.

It is to be emphasized that the supply of free thyroxine to the cells of the body should remain constant as long as the ratio of PBI to TBG remains constant. The rise in PBI during pregnancy is due to the rise in TBG and a similar change is observed during estrogen administration. On the other hand androgen and phenylhydantoin therapy are associated with a fall in the concentration of TBG and PBI whereas metabolic status, and presumably free thyroxine concentration remains normal. The PBI concentration correlates with the metabolic state in 95 per cent of subjects because 95 per cent have normal concentrations of TBG. (A recent report is pertinent: Four patients with unequivocal evidence of hyperthyroidism showed normal PBI values on repeated analysis. Decreased concentration of TBG was shown and it was postulated that free thyroxine was high whereas the normal PBI actually reflected the protein deficit.—Ed.)

With increasing understanding of thyroid physiology and biochemistry, a large number of laboratory tests of thyroid function have been devised. The physician must understand the basis of each test, the complexities of the manufacture and release of thyroid hormones and the body's effort to conserve iodide. He should know (1) what the test measures, (2) its accuracy and reproducibility, (3) the frequency of false negative results, (4) the frequency of false positive results, and (5) the value of the test in the evaluation of therapy.

The Basal Metabolic Rate—BMR

For years the only test for determining the status of thyroid function was to measure the basal metabolism. With the advent of newer thyroid function tests, skill in the use of the BMR has rapidly diminished.

This examination evaluates the overall energy exchange of the tissues; its basis is the oxygen consumption measured under standard conditions as compared to normal individuals. It measures or evaluates the net metabolic effect of thyroid hormone on the tissues. Although there is no absolute correlation between the BMR and thyroid activity, it does reflect the degree of thyroid dysfunction more faithfully than do most of the others.

If one uses the BMR, he must appreciate the errors of the method, the commonest of which is failure to achieve a true "basal state"; defects in equipment with incomplete absorption of CO_2, leaks of oxygen around the face mask, and discomfort of the patient. The BMR obviously measures other factors which affect oxygen consumption and the results must be correlated with clinical findings. It is of particular value in following the patient's progress under treatment. Various modifications incuding the SMR (somnolent metabolic rate—in which the patient is heavily sedated) have been evolved, but these are of doubtful value.

Serum Cholesterol

It has been hoped that serum cholesterol concentration would be of diagnostic value, particularly in children. The procedure has been of no real diagnostic value in hyperthyroidism and of very little value in hypothyroidism, and in our opinion should be abandoned as a test of thyroid function. (Nutritional status has a profound influence on serum cholesterol concentration; the cachectic hypothyroid patient may exhibit normal values, whereas high values are characteristic of the well-nourished hypothyroid patient.—Ed.)

Serum Protein-Bound Iodine (PBI)

The PBI is a measure of the circulating thyroid hormone level in terms of its total organic iodine content. The PBI assesses the balance between the thyroid output of thyroxine and triiodothyronine and the tissue uptake, and metabolism of these compounds. The amount of iodine included in the serum protein precipitate is measured.

This is a valuable test in that the patient does not need to be in the laboratory. Care must be taken to use glassware and syringes that have not been contaminated with iodine, and one must carefully question the patient about the use of radiopaque materials or drugs containing iodine in any form. The values in euthyroid individuals vary between 4 to 8 micrograms per 100 ml. 85 to 95 percent of hyperthyroid patients will have values above 7.5 mcg., whereas 85 to 95 percent of hypothyroid individuals will have values below 3 mcg. per 100 ml. of blood.

In a great majority of patients the PBI along with clinical history and examination will clarify the thyroid status. There are certain cases, however, where the PBI is either insufficient or unsatisfactory as a diagnostic aid. When the patient has been recently receiving inorganic iodine medication, the PBI may be artificially elevated. When the patient is releasing abnormal iodinated compounds from the thyroid—for example, in thyroiditis—the PBI may show a level higher than the true hormonal iodine. When the patient has received organic iodine compounds in radiography, or as medication, the PBI is falsely elevated and often for long periods of time. One must remember that a normal PBI may be obtained in a hypothyroid individual receiving iodine-containing medication or having recently undergone a diagnostic x-ray procedure involving the use of such compounds.

Under carefully controlled conditions, the PBI is probably the most accurate index of thyroid function, and is particularly useful in children and psychotic or unconscious patients.

Butanol-extractable Iodine (BEI)

This represents a modification of the PBI procedure which eliminates iodide and certain iodinated amino acids and is therefore a more selective measurement of thyroxine and triiodothyronine, but other organic iodine-containing compounds are not completely eliminated. The determination of BEI is technically more involved and more costly, and has not been generally adopted. It is a test for only occasional use. It has not proven its originally anticipated value in pediatrics.

Triiodothyronine Uptake by Erythrocytes or Resin

In 1957, Hamolsky, et al[14] reported that red blood cells bound I^{131} labeled triiodothyronine (T_3*) when this substance was added to whole blood *in vitro*. This new concept provided indirect evidence for the importance of TBG in thyroid hormone transport and has been proposed as a useful diagnostic test since it provides an index of the concentration of TBG which is available to bind the tracer hormone. In other words the erythrocytes bind the test hormone which is "left-over" after its interaction with the primary binding sites TBG) of the plasma proteins.

In hyperthyroidism the overproduction of thyroxine leads to "saturation" of the primary binding affinity of TBG and the major portion of the T_3* is secondarily absorbed by the red cells. In hypothyroidism the deficiency of thyroid hormone leaves much of the TBG unsaturated with thyroxine and added T_3* is largely fixed to TBG with little left for binding by erythrocytes. Therefore, it is apparent that an inverse relationship exists between T_3* bound to erythrocytes and the concentration of TBG which is still able to bind T_3*. This procedure has technical limitations due to repeated washing of erythrocytes, hemolysis, and difficulty in preserving whole blood prior to testing. Various modifications were developed to correct for variations in hematocrit and erythrocyte characteristics and Scholar [26] introduced ionic resins to replace the erythrocyte in the system.

The T_3* uptake is proving to be a valuable test of thyroid function and in 1960 Mitchell, et al[19] introduced a resin-impregnated sponge (a mixture of polyurethane foam and a finely divided anion exchange resin—Amberlite IRA-400) to take the place of the resins alone. One may add either serum or plasma to a sponge-

containing test tube, and preserve the material under refrigeration for determinations as long as a week later. This has the advantage that the patient need not come to the laboratory; there is no exposure to radioactive substance, and hence no interference with other tracer tests, and exogenous iodine, organic or inorganic, apparently does not interfere with the result.

In the interpretation of this test, one must take into consideration circumstances that expand and contract the TBG pool.

The T_3* uptake values are variously reported, with sex differences, as follows:

	T3 Value Range	Average
Euthyroidism		
Females	11-17	13.9
Males	11.9-19	15.2
Hyperthyroidism		
Females	17-35	22.5
Males	19.5-37.9	23.7
Hypothyroidism		
Females	6.1-11	9.3
Males	5.5-11.6	9.7

The normal values for the sponge-impregnated test will be variable, depending on the products of various manufacturers. In our own laboratory we are using a product called "TRIOSORB" produced by Abbott Laboratories. We have measured the PBI, the "TRIOSORB" and the resin absorption and have demonstrated a high correlation among these tests in three hundred simultaneous determinations.

Tests Based on the Inorganic Iodide Phase

Soon after radioiodide has been given the concentrations of the isotope can be measured in the urine, in the thyroid region, and in the circulating blood. The rate of accumulation of iodide in the thyroid can be charted to determine a gradient. Clearance of plasma iodide by the thyroid can be estimated by relating the amount of isotope in the gland to its concentration in the blood. The thyroidal clearance is expressed in ml. of blood cleared of iodide per minute. When the concentration of radioiodine in the thyroid is compared with that in the thigh, a ratio is established which is a rough estimate of clearance. This is done one to two hours after administration of the tracer dose of NaI^{131}.

These measurements of iodide accumulation or clearance are accurate but time consuming, and are not as simple as the "regular" uptake studies.

The 24-hour uptake study is most commonly used because the radioiodine in the thyroid reaches a peak at or near 24 hours. In an occasional patient the turnover of iodine will be more rapid and the 24-hour determination will not measure the peak. In such patients earlier uptake measurement must be carried out. Six-hour uptake studies will largely eliminate error due to rapid iodine turnover.

A normal 24-hour thyroid uptake of 15 to 45 percent of the tracer dose is dependent upon standard conditions of testing. The iodide pool must not be abnormally small because of low dietary intake or abnormally large because of intake of large amounts of iodine. The uptake estimates removal of iodide from the iodide pool and is of limited value in the presence of significant alterations in the size of the iodide pool. Drugs which impede the trapping of iodine or its oxidation must not have been used recently. The patient must not be receiving thyroid hormones because exogenous desiccated thyroid depresses TSH production and thereby lowers thyroidal uptake of iodide.

In hyperthyroid patients the uptake is usually above 45 percent, but the 24-hour uptake does not completely separate euthyroid and hyperthyroid patients. Besides hyperthyroidism, high uptakes will occur when dietary iodine has been low, when renal or heart disease has diminished the usual iodide excretion by the kidney, and when defects in the gland cause imperfect oxidation and combination of iodine with tyrosines such as occurs in some cretins. The withdrawal of antithyroid drugs will be followed by a period of high uptake which has been called the "rebound phenomenon." Rebound also follows withdrawal of iodine or thyroid extract, but is harder to recognize than that following use of thiourea derivatives. Nodular goiters in some euthyroid patients will also have high 24-hour uptakes.

The causes of low 24-hour uptakes are: hypothyroidism, excessive intake of iodine in any of dozens of ways, such as drugs, cosmetics, dietary fads, seafoods, x-ray contrast media, prior and continuing treatment with antithyroid drugs, acute and some cases of subacute thyroiditis, administration of thyroid hormone and other hormones which have suppressive effects upon the pituitary gland.

Many of the borderline cases may be subjected to special procedures used in connection with the 24-hour uptake. Controlled amounts of iodine will suppress uptake in hyperthyroid more than in euthyroid patients. Conversely, giving thyroid or triiodothyronine will suppress the uptake more in euthyroid than in hyperthyroid subjects. Perchlorates have been found to cause a release of trapped iodine from the glands of some cretins and in cases of Hashimoto's struma. Uptake studies before and after the administration of thyrotropin greatly aids differentiation of cretins, separating those with primary thyroid deficiency from those with pituitary deficiency.

Tests Based Upon Organic Iodine Phase

Within a few hours after radioiodine is given, thyroid hormone with the I^{131} label can be demonstrated in the blood stream. The level of protein-bound iodine 131 gradually increases and the level of unbound radioiodine decreases. At 24 hours a ratio of protein-bound to total radioiodine gives a reliable estimate of release of hormone, and conversion ratios above 50 signify hyperthyroidism. This procedure will help elucidate the problem in a patient with an unexpectedly low 24-hour uptake due to rapid turnover of radioiodine by the gland.

The level of protein-bound radioiodine continues to increase until near 72 hours. At this time the PBI^{131} determination will also help to differentiate borderline cases of hyperthyroidism from euthyroid individuals with relatively high uptakes. The upper limit of normal is 0.27 percent per liter of the administered dose of radioiodine.

I^{131} Localization Studies

The distribution of iodide in a nodular thyroid is important because the presumption of cancer can be eliminated in many cases. Correlation of clinical findings with operative results and the pattern of iodide distribution as shown by scanning brings to light the following: many nodules thought to be single are actually multiple, some multiple nodules prove to be due to thyroiditis; most cancers of the thyroid are in single nodules with little or no uptake of iodide in the nodule; very hot nodules are usually adenomas which cause suppression of hormone production by the rest of the gland and a very scant uptake of iodide except in the nodule; and substernal extensions can be confirmed by radioiodine localization studies. "Scanning" can disclose lingual thyroids and the fact that no thyroid tissue is present in the neck. Strumas of the ovaries take up iodide and can be diagnosed. Occasionally metastatic thyroid carcinoma will take up iodine and can be demonstrated by scanning. The relation of I^{131} to individual cells can be shown by autoradiography. For autoradiography, large tracer doses must be given two to three days before surgery.

Summary

The more common thyroid function tests have been briefly discussed in relation to the current concept of thyroid hormone production and transport. Emphasis has been placed on the newer studies of thyroid-binding proteins.

The evaluation of thyroid function tests in the final analysis depends on the physician whose main aids in diagnosis stem from his awareness of the clinical picture of altered thyroid function corroborated by careful history and physical examination, and by the results of appropriate therapy. Laboratory tests do not diagnose the clinical state of thyroid function. The selection of the laboratory test will depend to some extent on those that are available, and must depend on the physician's knowledge of the test, its accuracy, and significance.

We believe that proper combination of the PBI, T_3*, and radioactive uptake can do much to aid in accurate diagnosis.

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The Detection of Hyperparathyroidism

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HYPERPARATHYROIDISM continues to be one of the most elusive diagnoses in Medicine. There appear to be two major reasons for this fact, and some interdependence between the two exists. First, the manifestations of parathyroid hyperfunction are not such as to suggest this disorder to most clinicians. The other reason is that no sure and simple method exists for the proof of the presence of the hyperparathyroid state.

Is primary hyperparathyroidism, due to adenoma or to hyperplasia, a rare and infrequent endocrinopathy? The actual incidence of the disease among the general population is not known, its occurrence having been related, in published reports, to other pathological conditions. It is certain that positive diagnoses rise with an increased awareness of, and interest in hyperparathyroidism in various clinics or practices. Thus, Gordan[1] reports that from 1934 to 1954 nine proven cases of hyperparathyroidism had been found at the University of California Medical Center. In 1954 organized search for such cases was instituted with the result that 104 positive diagnoses were made in the next seven years. Prior to 1943, only 16 cases of hyperparathyroidism had been diagnosed at the Mayo Clinic[2]. Following the adoption of definitive screening techniques, 364 cases were proved in the next 18 years. Similar experiences have been encountered at the Cleveland Clinic[3] and elsewhere. Clearly, heightened awareness and intensified search will result everywhere in the recognition of a gratifying number of patients.

Such search is justified because hyperparathyroidism is a lethal disease. Recurrent urinary calculi, nephrocalcinoses, pyelonephritis, progressive renal failure, and hypertension are the consequences of untreated hyperfunction of the parathyroids. Hyperparathyroid crises, with abdominal pain, vomiting, prostration, oliguria and a rising blood urea nitrogen associated with a very high (18-25 mgm/100 ml.) serum calcium may cause death in a few hours unless skillful diagnostic and heroic therapeutic measures are used. Such crises, also known as parathyroid poisoning and hyperhyperparathyroidism may be associated with, and the proper diagnosis obscured by, the presence of peptic ulcer or pancreatitis[4,5,6]. In any acute abdominal state resembling partial, or complete intestinal obstruction, particularly with oliguria and rising blood urea nitrogen, serum calcium determination should be made. Hypophosphatemia is not usually seen because of the frequent association of renal insufficiency as a part of the syndrome.

When should the possibility of hyperparathyroidism pique the medical mind? Since Albright, in the nineteen-thirties, quickened interest in this disorder hyperparathyroidism has been known as a "disease of bones and stones." The primary action of the parathyroid hormone to increase the renal excretion of phosphorous was attended by the mobilization of phosphorous and calcium from the skeleton and accounted for the skeletal demineralization classically seen in primary hyperparathyroidism. The urinary tract calcification were attributed solely to the resulting hypercalciuria and hyperphosphaturia.

Additional direct action of parathormone on osseous tissue was demonstrated by Barnicot and by Chang[7] who implanted parathyroid tissue beneath the periosteum and observed the production of local areas of osteitis fibrosa. A third action is that of stimulating increased absorption of calcium from the digestive tract[8].

Most interestingly, Copp and co-workers[9,10], have reported a second parathyroid hormone which has the effect of *lowering* serum calcium, and which they call "calcitonin." No clinical instance of overproduction of this hormone has been noted, although the case reported by Frame and co-workers[11] of a patient with long-

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standing hypocalcemia and clear cell hyperplasia might represent this situation. Confirmation of Copp's studies is awaited with great interest.

In the United States, bone disease as the presenting chief symptom of hyperparathyroidism, is less common than calcification in the urinary tract, though we have seen three cases with extensive skeletal changes in one hospital in the last twelve years. Bradshaw[12] estimates that 10% of cases are diagnosed on the basis of roentgenologic change; in Keating's large series[2] approximately 17% of patients had mild to marked skeletal demineralization. The classical osseous manifestations of von Recklinghausen's Disease are too well known to require delineation in detail. Fractures, pseudofractures, bone cysts, "codfish vertebrae," cortical erosion (noted best in the phalanges) all require consideration of hyperparathyroidism as a possible cause. Strock[13] emphasized the diagnostic significance of visible or palpable tumors of the jaw, malocclusion or distortion of the normal arrangement of the teeth, cyst-like cavities of the jaws, and *diminished* dental caries. The fact that even in extreme demineralization caries does not increase is convincing evidence that hyperparathyroidism cannot bring about resorption of calcium and phosphorous from the mature teeth. Loosening of the teeth, however, may occur. It should be re-emphasized that while a single circumscribed area of rarefaction of bone may be prominent, it is quite impossible for parathyroid hormone excess to produce *localized* bone disease. This fact has made it desirable, in certain cases, to study bone biopsies for evidence of osteitis fibrosa generalizata. Such changes, it must be emphasized, are not specific.

It has been variously estimated that from 5 to 20% of patients with urinary tract stones have hyperparathyroidism[2,14,15,16]. Bradshaw[12] states that "renal disease produces symptoms leading to the diagnosis of hyperparathyroidism in 70% of cases". Nephrocalcinosis, however, as an indicator of parathyroid overactivity, is deprecated by Gordan[17] who believes that hyperparathyroidism accounts for only 2% of all patients with nephrocalcinosis.

In any case, calcifications within the urinary tract should always arouse suspicion of hyperparathyroidism. That such calicifications are not due to hypercalcemia alone is attested by the fact that other hypercalcemic states often do not cause stones. Reduced hydrogen ion excretion in hyperparathyroidism may be one of the factors responsible. If the offending stone is available, analysis particularly of the central portion or nucleus, is of value. The composition of the stone may be conjectured from its x-ray appearance.

It is not uncommon to delay consideration of parathyroid status until a patient has had recurrent bilateral urinary calculi. This is unfortunate, since in primary hyperparathyroidism the progress of kidney damage is inexorable, and procrastination may produce irreversible and lethal changes. Interestingly, Downs and Scott[18] reported the case of a parathyroid adenoma producing renal failure, hyperphosphatemia, and secondary hyperplasia of the remaining parathyroid glands. Such a sequence of events tends to refute Spiro's[19] statement that an adenoma can be diagnosed only if hyperplasia does not exist in the other parathyroids. (Theoretically a "true" adenoma should produce hypoplasia of the remaining parathyroid tissue.—Ed.)

Any calcification within the urinary tract demands the exclusion of the diagnosis of hyperparathyroidism.

Abdominal Groans

To the "stones and bones" concept of hyperparathyroid symptomatology, that of "abdominal groans" has been added by the oft-quoted report of St. Goar[20]. Sixteen of his 45 patients had prominent gastro-intestinal symptoms. Four had duodenal ulcers. Since St. Goar, many others have emphasized the frequency of digestive complaints. These may consist of anorexia, vague abdominal discomforts, and constipation. Spiro[19] states that a high serum calcium is associated with deposits of calcium in the stomach wall, and with gastric anacidity or hypoacidity. Mieher,[21] et al reported that 25% of a small series of cases gave a history of peptic ulcer. According to others[2,22,23] ulcers occur in 10-15% of hyperparathyroid patients. However, of 266 patients "screened" for evidence of parathyroid hyperactivity because they had peptic ulcer, Gordan[1] found only seven cases, and Ostrow [24] reported that five examples of hyperplasia, but no adenomas, were found in 812 autopsies of individuals with gastroduodenal ulcer.

The precise relationship between hyperparathyroidism and peptic ulcer or the peptic ulcer syndrome is unknown. The usual type of self-treatment of ulcer symptoms with large amounts of milk and anti-acids can cause confusion with the milk-alkali syndrome. Pearl, at el[25] cited the case of a male with duodenal ulcer who had taken large amounts of alkali and three to seven quarts of milk daily for relief of symptoms. Despite this regimen there were bouts of nausea and vomiting, and a weight loss of twenty-five pounds. Before abdominal surgery, diagnoses were bleeding ulcer, the milk-alkali syndrome, and renal insufficiency. Improvement of renal function following the removal of a parathyroid adenoma permitted the diagnosis of hyperparathyroidism. However, the patient died, and at autopsy a second parathyroid adenoma was found, as well as multiple islet call adenomas in the pancreas.

When symptoms of the peptic ulcer syndrome do not respond in the usual fashion to traditional treatment, hyperparathyroidism must be suspected. When this relationship does exist, removal of the abnormal parathyroid tissue is often followed by healing of the ulcer and relief from ulcer symptoms.

Pancreatitis as a clue to the diagnosis of hyperparathyroidism was emphasized by Cope, et al[26] in 1957. These authors also noted that serum calcium values might be reduced to deceivingly normal levels in the presence of acute pancreatitis, thus increasing the difficulty of diagnosis of hyperparathyroidism. Turchi, et al[27] used this fact as a basis for the suggestion that parathyroid overactivity should be suspected whenever a *normal* serum calcium value occurred in the presence of pancreatitis. Mixter and co-workers[28] noted that pancreatic lesions occurred eleven times in 155 cases of proved hyperparathyroidism. Difference of opinion exists as to the identity of the primary disorder; in experimental animals excessive parathormone administration can provoke necrosis of pancreatic tissue with calculus formation.

Vague Complaints

In addition to clear cut instances of peptic ulcer and pancreatitis, other abdominal discomforts and dyspepsias have been noted by several observers. Hypercalcemia is apparently responsible for the gastro-intestinal atony and constipation that occurs so frequently. Nausea, anorexia, and "bloating" are frequent concomitants of hyperparathyroidism, but also of many "functional" disorders, and it is clear that the earlier the disease is encountered or the milder its degree, the more vague are its manifestations. Polydipsia and polyuria, sometimes suggesting diabetes mellitus or insipidus, dull aching "bone pain," muscle weakness and hypotonicity, bradycardia, depression, apathy, any personality change in a previously well integrated individual may be expressions of the hyperparathyroid state. Definite psychoses have been associated with hyperparathyroidism, and have cleared after surgery, but psychoses also occur in connection with hypothyroidism. It has been suggested that the mental changes are related to the concentration of tissue or serum magnesium whose metabolism is related to that of calcium and phosphorous.

Laboratory Confirmation

Hypercalcemia is a *sine qua non* for the diagnosis of hyperparathyroidism. Individuals with parathyroid hyperfunction, however, may have normal serum calcium levels at times. Whether this is due to the variability of laboratory techniques or to changes in function of the offending tissue is not clear. Furthermore, in the presence of low serum protein concentration the *ionized* calcium, which is directly related to the degree of hyperparathyroidism, may be high, while the *total* serum calcium is not elevated. (Total calcium is the value reported by clinical laboratories.—Ed.) In any patient with evidence suggestive of hyperparathyroidism repeated serum calcium determinations should be made in order to establish or refute the diagnosis. (Routine serum calcium analyses are notoriously unreliable when systematic comparisons are made.—Ed.)

If an elevated level of serum calcium is found on one or several occasions, one has still established only the diagnosis of hypercalcemia. In Gordan's clinic hyperparathyroidism was second to malignancies as a cause of hypercalcemia. Other causes are vitamin D overdosage, hyperthyroidism, the milk-alkali syndrome, immobilization, sarcoidosis, multiple myeloma, Addison's Disease, and errors of technique. Most of these causes can be distinguished by history and usual examinations. Failing that, it has been held that the adminis-

tration of relatively large doses of cortisone for a week will depress serum calcium in non-hyperparathyroid conditions. However, Gwinup and Sayle [29] report a case of primary hyperparathyroidism in which the serum calcium fell quickly during the administration of cortisone.

Classically, hyperparathyroidism is characterized by a low serum phosphorous as well as a high serum calcium. Depression of renal function, however, can lead to phosphorous retention and a normal or elevated serum phosphorous. Harrison[16] reports several cases with normal serum phosphorous in the absence of renal deficiency, and others have noted the same. Some confusion exists as to what constitutes normal serum phosphorus. Albright held that normal levels were 3.5 plus or minus 0.5 mg. per 100 cc. Gordan's[1] normals are 2.6-4.3 mg. According to Nordin the serum phosphorous concentration is not definitely low unless it is below 2.4 mg./100 ml.

Advantage has been taken of knowledge of renal and parathyroid physiology in devising tests for excessive parathyroid function. Thus, an increased amount of parathyroid hormone lowers the renal threshold for phosphate by inhibiting tubular reabsorption, producing a low value for serum phosphorous, and an increased phosphate clearance. Schaaf and Kyle[30], through determinations of the creatinine and phosphorous content of urine and plasma, calculated the percentage of phosphate absorbed by the tubules (T.R.P.), and found that it was in the neighborhood of 90% in normal individuals. 75% or less in hyperparathyroidism. Howard, et al[31] studied the effect on serum and urinary phosphorous of calcium infused intravenously, and noted that in normal individuals phosphorous excretion fell as a result of suppression of parathyroid activity. Such a fall did not occur in the presence of primary hyperparathyroidism. Kyle, et al[32] have since suggested modifications of this procedure as having greater diagnostic importance.

Goldsmith, et al[33] propose a rapid calcium infusion test which measures fractionally the ratio: urine phosphorous/creatinine over a four hour period after infusion of calcium.

Determination of urinary calcium excretion is of value as a diagnostic aid. The simple Sulkowitch test for urinary calcium is only roughly quantitative but has some screening importance. For quantitative urinary calcium studies it has been usual practice to limit dietary calcium intake to less than 150 mg. Ca daily for several days before collecting a twenty-four hour specimen. We have usually determined the calcium excretion with the patient on an unrestricted diet. If this is less than 400 mgm., the imposition of a low calcium diet will not add information. In this connection, however, one should take note of Darnell's[34] observation that the calcium content of the local water supply is to be taken into account.

Summary

1. Primary hyperparathyroidism occurs with sufficient frequency and lethality to merit constant consideration as a clinical possibility.

2. Its successful detection is a matter of heightened suspicion and carefully conducted biochemical procedures.

3. Some avenues to this end have been indicated.

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Clinical Aspects of Adrenal Cortical Function With Special Emphasis on Cushing's Syndrome

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THE PAST 30 years have witnessed tremendous increases in the understanding of adrenal cortical function and, especially, of adrenal steroid chemistry. Familiarity with the spontaneous disorders of hyper- and hypofunction has increased and new syndromes have been delineated. Although knowledge of mechanisms of action of these hormones remains speculative, and some subtle disturbances remain obscure, it is now possible to establish definitive diagnosis with specific tests and to initiate successful treatment in many cases.[1,2]

Control Mechanisms

The control of adrenal secretions has been studied extensively and an increased understanding of its complexity has resulted. In general it is accepted that there are two systems: the "glucocorticoids" being primarily controlled by ACTH release from the anterior pituitary, whereas "mineralocorticoids" are largely independent of the pituitary and have perhaps two humoral agents (renal and cerebral in origin) which regulate their production.[3,4] In man the chief glucocorticoid is of course, cortisol (hydrocortisone), and aldosterone appears to be the primary mineralocorticoid. This division of the adrenal steroids into gluco- and mineralocorticoids is useful for discussion purposes but misleading if taken too literally.

While cortisol has dramatic effects on carbohydrate metabolism, it is also of importance in the regulation of protein and fat metabolism, growth, response to injury, inflammation, distribution of water and electrolytes, and a host of other physiological functions. Although it is much less potent than aldosterone in producing renal retention of Na^+ and excretion of K^+, cortisol is secreted in amounts approximately 100 times greater and therefore contributes approoximately one-third to one-half of the Na^+ retaining activity of the adrenal steroids under ordinary circumstances.

Much evidence has been adduced to show that a negative feedback system exists in the regulation of ACTH and cortisol secretion. Exogenous cortisol produces low rates of ACTH and cortisol secretion. Exogenous cortisol produces low rates of ACTH release and adrenal atrophy; deficiency of cortisol leads to hypersecretion of ACTH. This effect of cortisol may be directly on the anterior pituitary or on the hypothalamic centers which produce corticotrophin releasing factor (CRF) which is carried to the anterior lobe by way of the hypothalamico-hypophyseal portal system. The incorporation of the controlling mechanism in the hypothalamus brings it under the influence of the central nervous system which plays an important role in the regulatory mechanism. Under circumstances of stress (such as operation or injury) the feedback mechanism is altered so that the person or animal has continued ACTH release despite *increased* levels of steroids in the blood. This is presumed to be due to a change in the controlling centers so that they are no longer inhibited by greater than normal levels of circulating steroids—the regulatory center may be thought of as having been set at a new, higher level. The disastrous results of failure to attain high steroid output in severe stress conditions are well known to clinicans.

The control of aldosterone has also been under intensive investigation and it is now generally agreed that decreased effective circulating plasma volume is a primary stimulus to increased aldosterone secretion. It has been shown that the kidneys (juxta-glomerular apparatus) release renin under circumstances of decreased plasma volume and that by a chain of reactions this results in the production of angiotensin II which is not only a vasoconstric-

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tor substance but also stimulates the secretion of aldosterone by the outer layer (glumerulosa) of the adrenal cortex.[3] It is probable that neural pathways arising in volume receptors located in the great veins, atria, and carotid sinus also stimulate aldosterone secretion via a humoral agent released from the CNS in the area of the pineal gland and its surrounding structures.[4]

In addition to the steroids described above, the adrenals also secrete androgens and small amounts of estrogens. These substances contribute to pubertal transformation, including sexual hair, seborrhea, acne, and the adolescent growth spurt. It is not clear why the increased adrenal androgen secretion usually coincides with pituitary secretion of gonadotrophins and the development of the ovaries or testes. Theoretically this may be due to maturation of the adrenals themselves or to the humoral environment (increased gonadotrophin and gonadal hormones), or to the secretion of a new or different ACTH at this point in time.

Hyperfunction

Excessive secretion of any of the three types of steroids may occur in disease of the adrenals or in disturbances of the regulatory mechanisms. It is of some importance clinically to determine where the disturbance originates in order to direct therapy appropriately.

Congenital Adrenal Hyperplasia

An infrequent but fascinating and readily treatable group of defects give rise to the syndrome of congenital adrenal hyperplasia (CAH). This syndrome can now be included in the category of inherited metabolic defects. Genetic studies indicate transmission as an autosomal recessive. The adrenal secretory products in this condition are primarily androgenic and the usual result is virilization of the female or precocious sexual and somatic development of the male.

This dramatic clinical picture has been described in association with enlarged adrenals as long as 100 years ago, but only recently has treatment been successful. After many abortive attempts to suppress adrenal androgen output Wilkins et. al.[5] demonstrated in 1950 that the abnormal hormonal output was effectively decreased by cortisone with remission of the clinical symptoms and signs. Following this it became apparent that the congenitally hyperplastic adrenal is responding to excessive ACTH production that results from decreased coritsol secretion.[6] The androgenic compounds are metabolic by-products of these glands and virilization is the price paid for the compensation achieved by cortical hyperplasia.

Even more recently the intimate biochemical lesions have been identified in many cases. Congenital deficiency of three specific enzymes in the biosynthesis of cortisol have now been recognized. In each case a relative deficiency of cortisol leads to increased ACTH release and cortical hyperplasia. Metabolic products proximal to the deficient enzyme accumulate and lead to startling clinical disturbances. An excellent review of the clinical and biochemical disturbances has recently been published by Bongiovanni.[7]

In the common type of CAH virilization alone is present. This may be apparent at birth, early childhood, or in adolescence. It may produce urgent problems of proper sex identity due to ambiguity of the genitalia in genetic females. When recognized and treated promptly a completely normal development and sex role may usually be achieved In about one-third of the cases the block is so severe that cortisol deficiency may persist despite cortical hyperplasia. These individuals exhibit many of the signs and symptoms of Addison's disease and are characteristically unable to conserve sodium ("salt wasters"). They are unlikely to survive infancy unless recognized and treated vigorously.

A rare complication of CAH is hypertension. This results when there is a deficiency of 11 hydroxylase, the enzyme responsible for conversion of desoxycorticosterone and 11 de-oxy cortisol to corticosterone and cortisol respectively. The 11 de-oxy compounds which accumulate lead to salt retention and hypertension. The blood pressure elevation subsides with treatment.

Cortisol treatment is specific in all of these disturbances: ACTH release is inhibited, the adrenals atrophy, and abnormal steroid production ceases. Cortisol in this situation functions as replacement therapy, and therefore physiological doses are administered and the familiar side effects of steroid therapy do not occur.

Hyperaldosteronism

The existence of a potent mineralo-corticoid, long suspected, was proved when aldosterone was isolated in 1954[8] and was nearly immediately identified as the sodium retaining factor previously demonstrated in the urine of edematous patients.[9] Its hypersecretion has now been implicated in a variety of illnesses characterized by fluid retention. The common denominator of these disturbances is thought to be reduced effective plasma volume which through the mechanisms outlined above, leads to increased aldosterone secretion and Na^+ and fluid retention which may constitute a major symptom of the disease.

Following the isolation of aldosterone Conn promptly recognized and described a new syndrome resulting from primary hypersecretion of this homone.[10] This is characteristically caused by an adenocortical adenoma and although rare, is important as a curable form of hypertension. Conn outlines the following diagnostic criteria in a recent article[11] "Hypertension without Grade 4 retinopathy, hypokalemic alkalosis associated with decreased renal capacity to conserve potassium, increased secretion of aldosterone, excretion of normal amounts of 17-hydroxy corticosteroids, and the absence of hyponatremia." Surgical removal of the adenoma has resulted in many complete clinical cures.

Cushing's Syndrome

Cushing's in contrast to Conn's syndrome has been recognized as a disturbance of adrenal function for more than 30 years and relatively little has been added to the early clinical descriptions.[12] It should now be possible, however, to recognize the disease in its early stages and to initiate therapy before the depradations of the disturbance have become full blown. This is important because of the hazard to life in advanced cases and because of the slow rate of recovery of normalcy following correction of the disturbance.

Cushing attributed the disease to the pituitary gland following his observation of basophil pituitary adenomas in some cases. Subsequently it became obvious that these adenomas were not present in all cases and that similar lesions occur in individuals without Cushing's syndrome. The clinical features of this illness are, of course, seen in primary adrenal tumors (adenomas and carcinomas) and it was felt by some that bilateral hyperplasia was also a disorder originating in the adrenal rather than the pituitary. This view was reinforced by the unsatisfactory response frequently following pituitary irradiation in contrast to the excellent result achieved by adrenalectomy. More recent evidence suggests again that adrenal hyperplasia is usually secondary to hypersecretion of ACTH and is the manifestation of a disturbance either in the pituitary itself or in the hypothalamus.[13]

Diagnosis of Cushing's Syndrome

The clinical diagnosis of Cushing's syndrome is sometimes obvious. There may be a striking picture of weakness, fatigue, centripetal obesity, hypertension, striae, acne, virilization, easy bruising, poor wound healing, with increase $(Na^+):(K^+)$ ratio in the serum. However, diagnostic difficulties are greatly increased when the disease is in an earlier stage of development and when the problem is to rule out Cushing's syndrome in the individual who shows obesity, hypertension, and hyperglycemia. These patients are seen frequently in practice and careful laboratory tests must be applied in order to eliminate the possibility of a primary adrenal (or pituitary) disorder.

Clinical examination and ordinary laboratory tests do not suffice to clarify the adrenal status of these patients and specific measurements of the blood or urinary steroids must be carried out. The first step is to establish the presence of excessive secretion of hydrocortisone. While specific methods for estimating this hormone are available in some centers, methods ordinarily available are indirect and consist of measuring hydrocortisone and its major metabolites in the urine. The oldest measurement, 17-ketosteroid (17KS) excretion, is the least helpful in the diagnosis of Cushing's syndrome. This is because approximately two-thirds of the 17-KS excreted are of gonadal origin in the male and because hydrocortisone contributes only about one-fourth of the 17-KS of *adrenal* origin, the remainder being derived from adrenal androgens. In addition the 17-KS excretion may be nonspecifically depressed in a variety of diseases while adrenal cortical function in general remains adequate. Finally it has been shown that due to the harsh chemical treatment (boiling in HC1), many nonspecific color producing compounds may be

produced so that up to 75% of the "17-KS" measured may be artefacts of the method.

More recently the Porter-Silber method for estimating "17-OH steroids" and the Norymberski method for measuring "17-ketogenic steroids" have been shown to give much more reliable indices of the secretion of hydrocortisone. They measure similar substances, mainly metabolites of cortisol. The latter method includes more of these metabolites and therefore gives somewhat higher values. (Table 1)

TABLE I

	Porter-Silber (17-hydroxy steroids)	Norymberski (17-ketogenic steroids)
Steroids Measured	Cortisol & tetrahydro metabolite	Same
	Cortisone & Ampersand tetrahydro metabolite	Same
		Cortolone
		Cortol
		17-hydroxy-pregnanolone
		pregnanetriol
		pregnanetriolone
Normal Values		
Adult Males	4-12 mg/24hr.	5-17 mg/24hr.
Adult Females	4-8 mg/24hr.	5-12 mg/24hr.

Twenty-four hour urine collections are made in bottles containing a preservative such as toluene and the completeness of collection may be checked by estimation of the creatinine excretion. If the 24 hour excretion of 17-hydroxy steroids (17 OHS) or 17-ketogenic steroids (17 KGS) is within the normal range of several determinations the diagnosis of Cushing's syndrome is unlikely. This may be confirmed by the demonstration of a normal diurnal rhythm (decreased nocturnal secretion), a normal response to ACTH, or to dexamethasone suppression. (See below.)

If the urinary steroid excretion is elevated this may indicate the presence of Cushing's syndrome with adrenal hyperplasia or tumor, however, this may also occur in some cases of "simple" obesity. Further studies are required to clarify the situation.

Steroid excretion patterns useful in confirming or eliminating Cushing's syndrome (Table II)

1) Total 17-OH excretion may be increased in Cushing's or obesity.

2) Absence of diurnal variation strongly suggests Cushing's syndrome. Usually the excretion rate per hour will be one-half or less during the hours from 11:00 P.M.-6:00 A.M. as compared to the rate from 6:00 A.M.-11:00 P.M. (Some false positives have been encountered).

3) Suppression with potent glucocorticoid. When a steroid such as dexamethasone is administered to a normal individual the pituitary secretion of ACTH is inhibited just as it is with full doses of cortisol or other glucocorticoids. Dexamethasone, however, contributes little to the measurable urinary steroids (17-OH) and these substances show a sharp fall. Liddle first studied this response systematically as a method for differentiating adrenal disturbances.[13] 17-OH steroids in normal persons invariably fall to levels of less than 4 mg/24 hrs. when 2 mg. of dexamethasone are given daily for 2 days. Obese persons show a similar response. Persons with Cushing's syndrome due to hyperplasia or tumor show little or no suppression on this dose. With 8 mg. of dexamethasone for 2 days, persons with adrenal hyperplasia will usually excrete less than one-half of the control level of 17-OH steroids. Most patients with adenoma or carcinoma will fail to respond to either the 2 or 8 mg. dosage. (Since Liddle's description of this test a number of cases have been reported which failed to show the expected response, as was in fact predicted by Liddle at the time).

4) Metopirone stimulation. The drug methopyrapone, CIBA (Su-4885) acts directly on the adrenal cortex and produces a block of the 11-hydroxylase enzyme that is needed for the conversion of desoxycorticosterone and cortexolone (compound S) to corticosterone and hydrocortisone respectively. The decreased hydrocortisone production results in increased ACTH release since compound S is not effective as a pituitary inhibitor. There is a resultant increase in secretion of compound S which is measured in the urine as a 17-OH steroid. Normal and hyperplastic adrenals will show this response whereas the relatively autonomous carcinoma will not. Patients with adenoma usually do not respond, presumably because of autonomous function.

5) The well known eight-hour I.V. ACTH test may also be helpful in differentiating carcinomas and some adenomas from bilateral hyperplasia. The normal individual or the person with hyperplastic adrenals will show a three-to-five fold increase in 17-OH

TABLE II

Steroid Excretion (17-OH) in Cushing's Syndrome (as described in text)

Abnormality	Resting level	Diurnal Variation	Dexamethasone Suppression 2 mg.*	Dexamethasone Suppression 8 mg.*	Metopirone**	ACTH
Normals	Normal	Present	Suppression	Suppression	3-5 x increase	3-5 x increase
Obese persons	Normal or elevated	"	"	"	"	"
Cushing's with hyperplasia	Usually Elevated	Absent	No suppression	"	"	"
Cushing's with adenoma	Usually Elevated	"	"	No suppression	Little or no increase	±
Cushing's with carcinoma	Usually Elevated	"	"	"	No increase	No increase

* 2nd. day

** Day following metopirone administration

steroid excretion in the 24 hours in which the ACTH is administered. Adenomas may or may not respond to this stimulus and not. (Table II at top of page)

The use of these tests will usually give a clear idea of the adrenal pathology and consequently lead to rational therapy. *Caution*: Care is required in interpreting the reported results, as is true with all laboratory studies. A variety of substances including glucose and acetone may give false high values. An additional warning is necessary in the case of urinary steroids. These measurements, although well standardized, require skill and practice on the part of the laboratory technician. When performed only occasionally by a given laboratory the results should be viewed with great skepticism.

Importance of Accurate Diagnosis

The differentiation of the types of hypercorticism has theoretical as well as practical therapeutic implications. It is now recognized that Cushing's syndrome can originate in at least two and probably three or more locations.

1) The disturbance may be primarily adrenal in the case of benign and malignant cortical tumors. Effective treatment requires extirpation of the tumor. 2) In the majority of cases (approximately 70%) both adrenals are hyperplastic apparently due to excessive ACTH stimulation. This may be associated with a basophilic adenoma of the adenohypophysis, or less frequently, with a chromophobe adenoma. However, in approximately 50% no abnormality is present on microscopic examination of the pituitary. It is, therefore, presumed that Cushing's syndrome may result from a disturbance in the secretion of CRF by the regulatory centers in the hypothalamus, or abnormal function of higher CNS centers.

Liddle et al[14] have recently reported increased ACTH levels in Cushing's syndrome with adrenal hyperplasia, pointing to a primary pituitary disturbance. This is corroborated by the successful treatment of these patients by pituitary irradiation therapy when this modality is properly applied.[15] Furthermore, it was shown that in some cases, after successful treatment with pituitary irradiation, the secretion of ACTH by the remaining viable pituitary may still be abnormal in that it is resistant to dexamethasone suppression. This again suggests a pituitary or higher disturbance and is similar to the abnormal resistance to suppression by thyroid of individuals with Graves' disease.[16]

It is clear that pituitary irradiation is the most logical therapy in Cushing's syndrome with adrenal hyperplasia. This conclusion has recently been reinforced by the late development of ACTH-secreting tumors of the pituitary in patients successfully treated one to four years previously by total adrenalectomy.[17] In these cases the removal of the adrenals may have acted as a stimulus to tumor formation (or development) whereas pituitary irradiation might prevent this occurrence and produce satisfactory remissions in a high percentage of cases. Since surgical excision is the only effective method for treating tumors of the cortex it is obviously important to be certain of the state of the adrenal (hyperplasia or tumor) in planning therapy.

Treatment

Radiation: If a diagnosis of adrenal hyperplasia can be established with assurance, a program of pituitary irradiation may then be commenced. This may be delivered from conventional sources in doses of 3-4000 tissue roentgens over a period of 30-40 days. Remissions have also been obtained following local radiation from pituitary implants of radioactive gold or yttrium. Effective radiation therapy has been followed by clinical remission in 70-80% of a well documented series.[18]

Adrenal Surgery: Many regimens have been suggested for adequate therapy during and after adrenal surgery. The following program[19] has been followed successfully by the author. The basic points are: (1) adequate replacement with water soluble cortisol during the time of severe stress, (2) prompt and adequate administration of Na^{+} retaining hormone in all cases of bilateral extirpation.

Program

Pre-op day	6:00 P.M., 50 mg cortisone acetate I.M. 4 sites (total 200 mg.)
Op-day	6:00 A.M., 50 mg. soluble cortisol (Hydrocortisone) I.M.—2 sites (total 100 mg.)
During op	100 mg. cortisol with each 500 ml. I.V. fluid. If both glands are removed, 5.0 mg Desoxycorticosterone acetate (DOCA) in oil, I.M.
Post-op	1) 50 mg soluble cortisol I.M. q6h until oral therapy begins; then cortisone acetate 25 mg p.o. q8h, followed by a slow reduction in oral cortisone. 2) If complete adrenalectomy, same as above plus DOCA 5.0 mg. q.d. When oral therapy begins start 9a-fluorohydrocortisone, 0.1 mg. q.d.

Cushing's Syndrome and Non-pituitary Neoplasms

Recently an increased number of patients have been reported with non-pituitary neoplasms who exhibited the signs, symptoms, and steroidal abnormalities of Cushing's syndrome. This is most common in association with carcinoma of the lung but has also occurred with a variety of cancers. This phenomenon has been studied in Liddle's laboratory with the successful demonstration of ACTH activity in the blood and in the tissue of the tumor.[20] Sometimes the adrenal disturbance clinically outweighs the symptoms due to the cancer and adrenalectomy has been performed as a palliative procedure. Otherwise, the course of the hypercorticism rests on the success with which the primary tumor can be controlled.

Iatrogenic Cushing's Syndrome

Since synthetic glucocorticoids became available for treatment of a number of chronic diseases, iatrogenic Cushing's syndrome has become by far the most common form of the disease. It is of interest that all of the classic features of the disease can be induced by the administration of cortisone or other glucocorticoids, which substantiates the belief that excessive cortisol secretion is the major abnormality in the naturally occurring illness. In addition to the vast number of undesirable and/or dangerous side effects that are all too familiar, the loss of normal responsiveness of the pituitary-adrenal axis has created another hazard to the patient which may persist for many months after therapy has been discontinued. This is the development of cardio-vascular collapse following stress, especially during surgical procedures. It has been shown clearly that this is not due to adrenal atrophy and unresponsiveness to ACTH but is probably the result of loss of sensitivity of response of the pituitary and/or hypothalmus. Unfortunately there is no means of predicting whether this is a hazard in an individual case except by laboratory tests. If a normal response occurs to a single infusion of ACTH or to Metapirone it is probable that no supplementary steroids are necessary. These tests require time and expense and, therefore, when doubt exists (history of steroid therapy in suppressive doses greater than 25 mg. cortisone or equivalent daily for more than three weeks, within the past 12-18 months) the usual procedure is to administer adequate amounts of glucocorticoids before, during, and following the operation. The amount and duration of therapy may be varied according to the procedure.

Illustrative Cases

Case #1—J.F., UKMC, 00-08-29

42, W.M. Weight gain for 10 years; increasing dyspnea and orthopnea—3 years, fatigue and swelling of legs—1 year. Noted purple striae on abdomen 2-3 months. Somnolent. Family history positive for diabetes. P.E. BP 190/125. Wt. 327 lbs. Tremendous obesity mainly of trunk. Plethoric. Dyspneic. Acne. Brilliant red striae, 1-2 cm. in width over lower abdomen. Edema of legs. Hct. 58, FBS 268 mg.%. Skull film normal.

Steroid Excretion

	17-OH mg/24 hr.	17-KS mg/24 hr.
Control	17	15
Dex. 2.0*	12	8.0
Dex. 8.0*	2.4	3.8
3 mo. After Rx.	11	15
6 mo. After Rx.	3.0	..

*Dexamethasone mg/day; 2nd. day

Treatment: 4000 r to pituitary. Reducing diet. 1 year later had lost 90 lbs. Free of all previous symptoms. BP 120/80. No dyspnea or edema. FBS 130 mg.%

Comment: Failure of suppression on 2.0 mg. dexamethasone suggests adrenal hyperplasia rather than simple obesity. Persistent elevated FBS indicates probable diabetes mellitus previously aggravated by Cushing's syndrome. Normal 17 KS.

Case #2—L.T., UKMC, 01-00-31

21 year old C.F. 3 years previously had subtotal adrenalectomy at another hospital. Had complained of weight gain, acne, hirsutism, amenorrhea, back ache, fatigue, lactation. X-ray showed enlargement of sella turcica with thinning of the dorsum. Symptoms were alleviated post-operatively but all recurred 5 months before admission.

BP 142/82. Hirsutism, acne, centripetal obesity (mild), purplish striae and lactation. Diabetic glucose tolerance test. Skull x-ray unchanged from 3 years previously.

Steroid Excretion

	17-OH steroids	17-ketosteroids
Control	16 mg/24 hr.	23 mg/24 hr.
Dex. 2.0 mg.*	7	15
Dex. 8.0 mg.*	3	10
ACTH	42	48
1 mo. After Rx.	12	..
8 mo. After Rx.	6	14
11 mo. After Rx.	10 (17-KGS)	14

*Dexamethasone mg/24 hrs.; 2nd day

Treatment: 4000 r to pituitary with gradual subsidence of all symptoms. Eleven months later patient felt well, had regular menses, less acne and hirsutes. Glucose tolerance curve nearly but not quite normal.

Comment: Illustrates the danger of recurrence following subtotal adrenalectomy and the desirability of pituitary irradiation in bilateral hyperplasia. Sellar enlargement suggests pituitary adenoma, another indication for irradiation. Elevation of keto-steroids is in contrast to Case # 1 and is consistent with prominent masculinization in this case.

Case #3—J.T., UKMC, 00-53-60

23 year old WM 4 year history of weight gain, trunk obesity, fatigue, muscle weakness, headache, hypertension, abdominal striae, edema, bruisability, poor wound healing. P.E. BP 146/94. Patient presented with picture of full blown Cushing's syndrome that was unmistakable.

Steroid Excretion

	17-OH steroids	17-ketosteroids
Controls	8-18 mg/24hrs.	6-8 mg/24hrs.
Day	0.6 mg/hr.	
Night	1.0 mg/hr.	
ACTH (1 day)	16	
" (3 days)	24	
Dex. 2*	6	
Dex. 8*	10	

*Dexamethasone mg/24hrs.; 2nd. day.

Treatment: Bilateral total adrenalectomy. Adrenals weighed 8gm. each (normal) had nodular contour with thickening of zone reticlaris. Microscopically there was widespread nodular hyperplasia of zone reticularis. Postoperatively patient had stormy course with severe wound infection. Six months later is gradually losing the appearance of Cushing's Disease. Strength improved. BP 130/90. Glucose tolerance normal.

Comment: Resting levels of 17-OH steroids were variable and frequently elevated. Normal diurnal rhythm was reversed. The lack of response to ACTH, dexamethasone, (and metapirone) suggested a degree of autonomy consistent with cortical adenoma. Surgical adrenalectomy was, therefore, carried out and bilateral hyperplasia was discovered. Clinical response has been satisfactory.

Summary

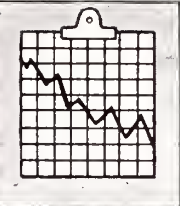
The current knowledge of adrenal cortical

(Continued on Page 903)

CASE DISCUSSIONS

From The

University of Louisville Hospitals



Louisville General Hospital

Management of Postoperative Pulmonary Complications

L.G.H. #122760—This 33 year old Negro female was admitted to the Louisville General Hospital a few minutes after being shot in the abdomen with a .22 caliber pistol. She was taken directly to the operating room where examination revealed a very obese female (weight, 285 pounds) who was in shock with a blood pressure of 80/60, pulse 110, and respirations, 30. A bullet wound was located in the left upper quadrant of the abdomen at the mid axillary line. Immediate laparotomy was undertaken.

Because the patient had recently eaten, intubation of the trachea was performed under topical anesthesia utilizing a transtracheal block with 4 ml of 0.5% tetracaine. After introduction of the endotracheal tube and inflation of the cuff, general anesthesia was begun and maintained using cyclopropane and oxygen in a closed circle carbon dioxide absorption system. Respirations were controlled throughout the five and one-half hour operation, and 300 mgm of succinyl choline were given over the course of the procedure to provide muscular relaxation. Six units of whole blood were administered to restore the blood volume and maintain the blood pressure. Operation consisted of laparotomy, splenectomy, repair of gastric and colonic bullet wounds and drainage of the pancreatic bed where extensive damage had been caused by the bullet which was lodged in the paraspinal muscles and was not removed.

At the conclusion of the operation, the patient was breathing spontaneously and was taken to the recovery room where the endotracheal tube was removed after the patient had returned to full consciousness. The patient was discharged from the recovery room 24 hours after the operation and appeared to be doing well at that time. A pulse rate of 104 beats/minute was attributed to hypovolemia, and an additional unit of blood was given on the ward.

The next morning (48 hours postoperatively), the patient was found *in extremis,* with labored respiration at 36/minute, pulse 130 and oral temperature 104°F. Coarse rhonchi were audible throughout both lung fields. The patient was returned to the recovery room where a tracheotomy was performed and tracheal suction carried out. The patient was then connected to the Mörch piston respirator via the tracheotomy and artificial ventilation of the lungs by intermittent positive pressure was begun.

Her condition improved immediately. The pulse decreased to 80/minute; the color was good and restlessness disappeared. Following repeated tracheobronchial aspiration, the lungs became clear except for an area of rales and decreased breath sounds over the right middle lobe.

Artificial ventilation was continued for 72 hours and then discontinued. The lungs were clear at this time and the patient was returned to the ward. No further respiratory difficulties occurred.

Her surgical convalescence was stormy, however, and marked by fecal fistula, subdiaphragmatic abscess on the left, and thrombophlebitis. Within six weeks of the original admission, she was well enough for discharge. The fecal fistula had closed, but drainage persisted from the site where pancreatic drains had been inserted. On the basis of x-ray studies, this drainage was thought to come from the subdiaphragmatic abscess cavity.

Two months later, the patient was readmitted with fever and productive cough of three days' duration. A diagnosis of pneumonia was made and treatment with antibiotics begun. She rapidly became afebrile, but the cough persisted.

A bronchogram demonstrated a communication between the tracheobronchial tree and the persistent left subdiaphragmatic abscess cavity.

Operation was proposed to establish adequate drainage of the subdiaphragmatic abscess and close the communication with the tracheobronchial tree. The patient was prepared for surgery with blood transfusions and frequent aspiration of the tracheobronchial tree. At the time of operation she was afebrile and the chest was clear. Very little sputum was being produced. Her weight remained at 285 pounds.

A second laparotomy was performed approximately six months after the original injury. The fistulous tract was excised and the abscess widely drained. Anesthetic management was essentially the same as before, using cyclopropane and oxygen after induction with 300 mgm of thiopental and endotracheal intubation with the aid of 60 mgm of succinyl choline. The operative course was uneventful.

Because of the obesity and history of previous postoperative pulmonary difficulty, a tracheotomy was performed at the conclusion of the operation and the patient placed on the Mörch piston respirator. Respirator therapy was continued for 96 hours and then discontinued. Postoperative convalescence was uneventful, and the patient left the hospital on the 18th postoperative day. Eradication of the subdiaphragmatic abscess cavity was complete.

Discussion

Donald M. Thomas, M.D., Assistant Professor of Anesthesiology, University of Louisville School of Medicine:

While this case presents many interesting aspects, we shall focus our attention on only one — namely, the postoperative pulmonary complications.

Upper abdominal surgery in an extremely obese patient such as this one certainly presents favorable conditions for the development of post-operative atelectasis, or pneumonia, or both. In such a case, vigorous efforts to prevent these complications must be made, including the familiar routine of turning, coughing, deep breathing and tracheal aspirations. This routine was followed in this case, but it was not enough to prevent the development of complications.

There can be little doubt that atelectasis was present at the time of the patient's discharge from the recovery room, as evidenced by the presence of tachycardia, tachypnea and fever. Vigorous therapy, including bronchoscopy at this time might have corrected the situation.

The use of intermittent positive pressure respirators in the post-operative period is becoming more widely accepted. The use of this equipment is of particular value in the very obese patient. Here, as in the majority of patients with postoperative pulmonary complications, it is necessary to ventilate the lungs with an adequate volume of air by means of a clear airway of adequate diameter. The mere administration of oxygen and the performance of a tracheotomy are not enough when the patient cannot or will not ventilate himself or herself in adequate volume because of impaired chest motion (obesity, rib injuries, tight dressings), pain with splinting, and respiratory depressant effects of anesthetic agents, muscle relaxants and narcotics.

Ventilation of the lungs with an adequate volume of air can be done by a number of mechanical devices, but the Mörch piston respirator has many unique advantages. It is very simple to operate, functions reliably, provides complete freedom of access to the patient for nursing care, and ventilates the patient with room air, thus eliminating the cost of compressed air or oxygen. Unlike pressure cycled or pressure limited ventilators, the Mörch respirator delivers the desired volume of air more or less independent of pressure. It is thus more readily able to cope with the problem of ventilating the patient who has increased airway resistance with or without decreased pulmonary compliance.

The major disadvantage of the Mörch respirator is its failure to bring about adequate humidification of the inspired atmosphere. This may lead to crusting of secretions in the tracheobronchial tree. We have found that the instillation of a small amount of sterile saline into the tracheobronchial tree at hourly intervals followed by aspiration of secretions prevents crusting of secretions to any noticeable extent.

Following the patient's second operation, the respirator was used as a prophylactic measure against the development of pulmonary complications. This attempt was apparently successful. While one would hesitate to recommend tracheotomy and respirator care for every obese patient undergoing upper abdominal surgery, it can and should be done in selected cases such as this one.

We have found it helpful in the extremely

(Continued on Page 901)

The Lady Governors of the Old Men's Home at Haarlem FRANS HALS, 1580/81-1666

In Geriatrics...

METAMUCIL® Provides Bland Smoothage

brand of psyllium hydrophilic mucilloid

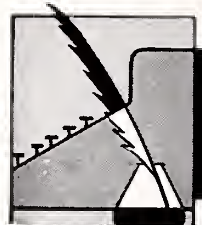
The tendency of the elderly to subsist on low-residue foods often is a prime cause of bowel sluggishness. Adequate fecal content is necessary to maintain normal colonic function, since intracolonic distention is nature's method of stimulating reflex peristalsis.

Metamucil, therefore, fulfills a basic function in the treatment of geriatric constipation. It both softens hard, dehydrated fecal concretions and adds smooth, nonirritant, easily compressible hydrophilic bulk.

Metamucil applies a physiologic principle to correct constipation naturally.

Average Adult Dose: One rounded teaspoonful of Metamucil powder (or one packet of Instant Mix Metamucil) in a glass of cool liquid. To Metamucil powder, a refined, purified and concentrated psyllium hydrophilic mucilloid, an equal amount of dextrose is added as a dispersing agent. Each dose of the powder furnishes a negligible amount of sodium and 14 calories. To the mucilloid in Instant Mix Metamucil citric acid, sodium bicarbonate and mild flavoring are added. Each dose of Instant Mix Metamucil furnishes 0.25 Gm. of sodium and 3 calories. Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons of 16 and 30 single-dose packets.

G. D. SEARLE & CO.
CHICAGO, ILLINOIS, 60680
Research in the Service of Medicine



EDITORIALS

Diabetes Detection

THERE are still an estimated 15,000 Kentuckians and 1,000,000 other Americans who have undetected diabetes mellitus. The week of November 17-23 marks the 13th annual drive to detect as many of these hidden diabetics as possible. This unique non-fund raising drive, annually sponsored by the Kentucky State Medical Association in conjunction with the American Diabetes Association, has already detected nearly 2,000 diabetics in Kentucky since its inception 12 years ago.

All physicians are requested to give free urine tests to every patient visiting his office during Detection Week and to test all of his patients at least once a year. Free testing materials are available through your county diabetes detection committee chairman. Your committee believes this annual Diabetes Detection and Education Drive is a most effective builder of good will for the medical profession as well as an important public service. Clinicians are the first and main line of treatment. It is for these reasons that the committee especially wishes to stress this year the doing of the testing in physicians' offices.

Every physician is also asked to tell his patients why diabetes is important to them and to the community and to advise them to have members of their families tested for sugar in the urine. There is a need to make the community "diabetes conscious"—aware of the need for detection and control.

Finally, the aim of the campaign is not merely to find the hidden diabetic but to get him to his family doctor. Also, it is necessary to make sure that all physicians receiving positive reports follow them up with blood sugar determinations preferably two hours after a full meal or a carbohydrate load, and other tests to establish whether or not diabetes is present.

The Diabetes Detection Committee wishes to express appreciation to all physicians who will by their participation and cooperation in Diabetes Week, November 17-23, help make this one of the most successful yet.

Robert S. Tillett, M.D.

Syphilis

THE sustained and rapid reappearance of one of mankind's oldest enemies — Syphilis is again upon us. The tremendous increase in early infectious syphilis from a low point in 1957 of 6,251 reported cases or 3.8 per 100,000 population, the disease has bounded back to 20,084 reported cases in 1962 for a case rate of 11 per 100,000. Many of you are undoubtedly aware of this through recent articles in journals, the press and television. The disease has not changed but the times have. No longer does it require long and difficult treatment schedules—penicillin has changed that. No longer is it a disease of the lower socio-economic class or of the older population as shown by the fact that in 1962 the under twenty-four group accounted for 45.7 percent of all reported infectious syphilis. No longer is syphilis a problem only for public health medicine—the out-patient treatment with penicillin has made it a disease easily treated in any private physician's office.

It is for this reason that every private physician must be aware of his responsibility toward his patient as well as the community. Failure to report cases places both in jeopardy. Since a very liberal estimate would indicate that at best, private physicians are reporting only fifty percent of their cases to health authorities, responsibility for failure to control this intolerable disease will eventually be placed on private physicians unless they begin to enter wholeheartedly into a cooperative effort with public health personnel.

This effort must include:

1. Complete reporting of all cases to the health department; such reports of course remain absolutely confidential.

2. Allowing trained Epidemiologists to interview the patient for sexual contacts. Such interviews are never performed without first obtaining the permission of the private physician and are always done in a professional, confidential manner.

3. Requesting all reactive serologic tests for syphilis performed in private laboratories to be reported immediately to the health department. Such reports do not constitute morbidity reporting but rather serve as an alert mechanism to the health department in order that they might offer the above service of epidemiology. No attempt is ever made to contact a patient directly on the basis of a laboratory report.

The KSMA Committee on Public Health strongly endorses and recommends full cooperation in the above program. Since syphilis is a communicable disease required by law to be reported, we should neither have to be coerced into fulfilling our obligations, nor should we delay in cooperation anymore than we would hesitate to report a case of smallpox, diphtheria or typhoid. Eradication of this disease will depend on the cooperation of the private physician in a team effort with public health personnel.

Delmas M. Clardy, M.D.

What is Our Responsibility November 5?

You have a major interest in the November 5 General Election! If you did not register by September 7, it's too late. Those of us who have registered will have the opportunity and privilege of voting for the candidate of our choice.

Every office, and the individual serving the office, is important. With the exception of nominees for State Representatives, all elected candidates in November will serve for a period of four years. The representatives will serve two years.

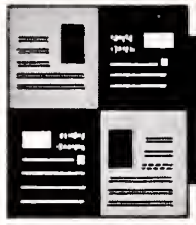
Our elected officials will determine how our tax money will be spent. They will decide the amounts that will be used for education, roads, health, parks and community development projects.

Regardless of the occupation of any individual, his livelihood is effected by the results of any election. A physician has as much or more at stake than the average person because he pays a large portion of the tax dollar. This being the case, he should have as much or more interest than the average citizen in those elected to public office.

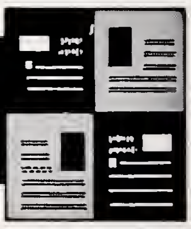
As physicians and good citizens it is our duty and responsibility to contact the candidates, have our friends contact them, and exchance views we think important to us as Kentucky citizens. It is far more important that this be done before November 5 than it will be after the election and for the next four years.

Unless more of us become more active in politics and work for the candidate of our choice at the precinct level, then it is only reasonable that we will be less effective when we approach the officials who represent us. It is encouraging to observe that more physicians are becoming better citizens by taking an active part in politics.

John C. Quertermous, M.D.



SPECIAL ARTICLES



A Glimpse Into The Life Of Doctor Ephraim McDowell (1771-1830)*

George W. Grider** and Norman H. Franke***
Danville, Ky.

DR. Ephraim McDowell, born in 1771, was reared in Danville, Kentucky. After serving an internship under Dr. Alexander Humphreys of Staunton, Virginia, McDowell travelled to Scotland and studied at the University of Edinburgh under the famous Dr. John Bell.[1]

In 1795, probably earlier, in partnership with a Dr. Rankin, he began the practice of medicine in Danville in a small shop, restored in 1959. The shop may be the first drug store West of the Allegheney Mountains.[2] The furnishings, all authentic, date between 1790 and 1850.

Next to the shop is the restored home in which he performed the first successful removal of an ovarian tumor in 1809, pioneering the field of abdominal surgery.

The only letter extant in McDowell's own hand describing the operation was written to a fellow Kentuckian, Dr. Robert J. Thompson, then a medical student in Philadelphia. Dated January 2, 1829, the letter reads:

Danville January 2, 1829

Mr. Robert Thompson
Student of Medicine
No. 59 Spruce Street
Philadelphia, Pennsylvania
Sir,

At the request of your father I take the liberty of addressing you a letter giving you a short account of the circumstances which lead to the first operation for diseased ovaria. I was sent for in 1809 to deliver a Mrs. Crawford near Greentown of twins; as the two attending physicians supposed. Upon examination per vaginam I soon ascertained that she was not pregnant; but had a large tumor in the abdomen which moved easily from side to side. I told the lady that I could do her no good and carefully stated to her, her deplorable situation. Informed her that John Bell, Hunter, Hay and A. Wood four of the first and most eminent surgeons in England and Scotland had uniformly declared in their lectures that such was the danger of peritoneal inflammation, that opening the abdomen to extract the tumor was inevitable death. But not standing with this, if she thought herself prepared to die, I would take the lump from her if she could come to Danville. She came in a few days after my return home and in six days I opened her side and extracted one of the ovaria which from its diseased and enlarged state weighed upwards of twenty pounds. The intestines as soon as an opening was made run out upon the table, remained out about twenty minutes and being upon Christmas Day they became so cold that I thought proper to bathe them in tepid water previous to my replacing them; I then returned them, stitched up the wound and she was perfectly well in 25 days. Since that time I have operated eleven times and have lost but one. I now can tell at once when relief can be obtained by an examination of the tumor if it floats freely from side to side or appears free from attachments except of the lower part of the abdomen. I advise the op-

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*Presented at the meeting of the Section on Historical Pharmacy of the A. Ph. A. at Miami Beach, Florida, May, 1963.

**Pharmacist and Curator of the McDowell House and Apothecary Shop, Danville, Kentucky.

***Pharmacist and Associate Professor at the College of Pharmacy of the University of Kentucky at Lexington.

1. Schachner, A., Ephraim McDowell, Philadelphia, 1921, pp. 1-21.
2. Possibly the first such shop may have been that of Drs. Duke and Ridgley, opened in Lexington, Kentucky, 1793.

eration, having no fear from the inflammation that may ensue. I last spring operated upon a Mrs. Bryant from the mouth of Elkhorn from below Frankfort. I opened the abdomen from the umbilicus to the pubis and extracted sixteen pounds. The said contained the most offensive water I ever smelt, and the attendants puked or discharged except myself. She is now living; from being successful in the above operation. Several young gentlemen with ruptures have come to me. I have uniformly cut the ring open, put the intestines up if down then cut the ring all around, every quarter of an inch then pushed the parts closely together and in every case the cure has been perfect. Therefore, it appears to me a mere humbug about the danger of the peritoneal inflammation. Much talked about by most surgeons. After wishing you Health and Happiness.

I am yours sincerely,
E. McDowell

P.S. Your father looks better than I have ever seen. Your sister is also in health.

There is also extant a letter written to Mr. John Shelby, Dr. McDowell's brother-in-law, son of Isaac Shelby, the first Governor of Kentucky. This brings us a glimpse of the personal side of the doctor's character and explains his known hatred of the British. You will note that but for a few changes in the names and places, this letter, dated January 8th, 1815, might have been written yesterday.

"Dear John

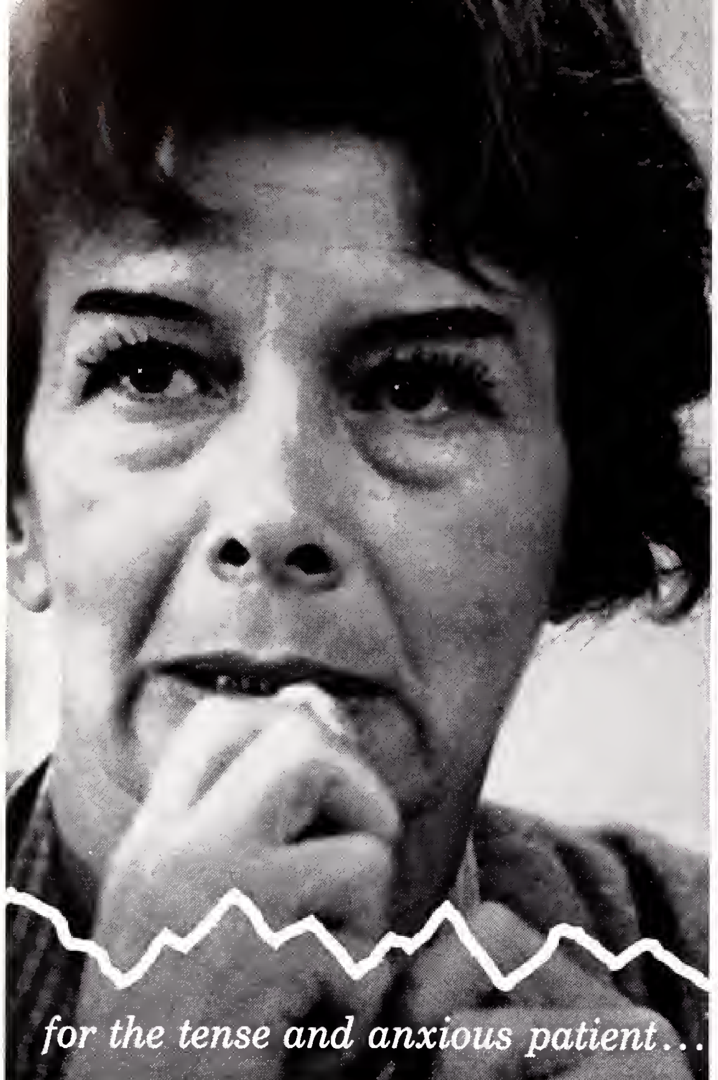
I am pleased with an opportunity by Mr. Bell to inform you we are still breathing, but for how long that will be the case God only knows, for I fear what with the heavy taxes and the forlorn prospects of our fiscal affairs; together with the threatening aspect of dissolution of Union in the northeast we shall not be able to breath much longer. Unless some providential occurrance saves this country from the horrors of internal convulsions; our horizon appears to thicken daily and what will be the end time can alone develope: let the hell hounds of England get possession of Orleans and this country may feel it for years to come. But we have a Jackson there whom I hope will defend the City until the British vessels can be taken to the Lake from the Mississippi having the blood of their own countrymen sufficiently deep for the each transportation of their vessels; the Kentuckians ought to rise en masse to defend that important key to this western country.

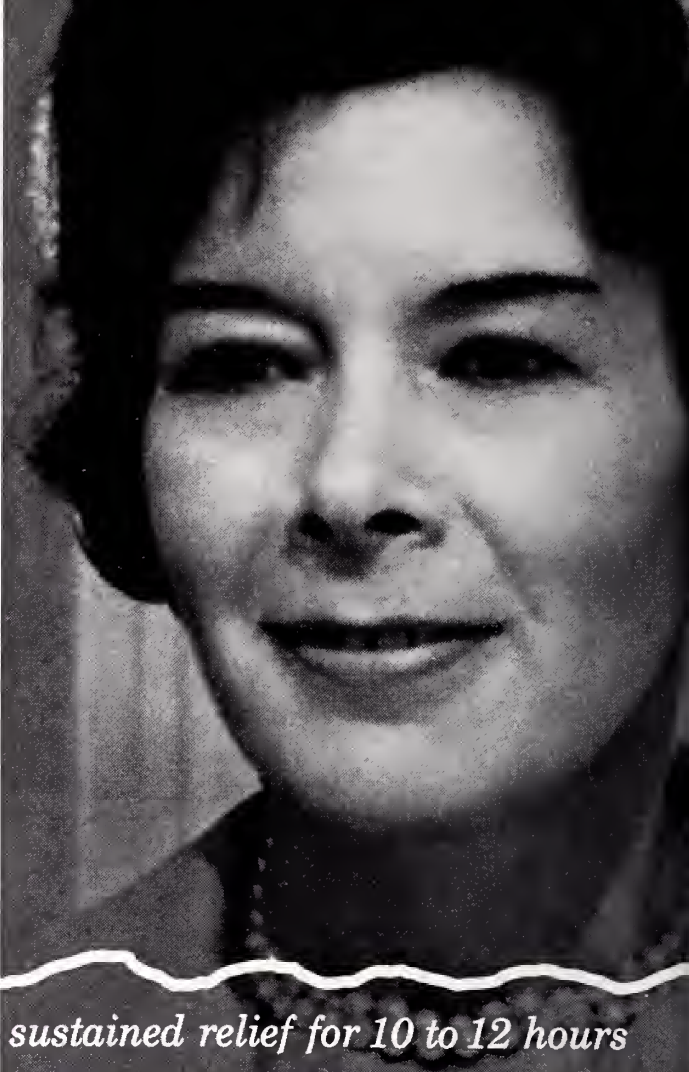
Isaac tells me he left S. Lewis' note with you. I hope my dear friend you will not fail to wait upon him as soon as you hear of his getting home and receive the money for me in silver or Kentucky notes at Par, Virginia notes at ten per cent deduction (and on other notes I have been paid ten per cent interest for waiting). Tell Susanna I flatter myself she is very industrious this winter; and that when I see her some months hence I will be surprised at her progress in every female science; and that she must write to me when ever she wants books or any thing else. Remember me affectionately to the family and let Sachta know that I wish to hear if any material injury is done to her heart that medicine may be prescribed before it be too late.

Believe me to be your
Sincere Friend
E. McDowell
January 8th, 1815

P.S. Get ten per cent if you can if not 6 per cent interest upon Lewis' note.

Both letters are preserved at the McDowell House Restoration.





Smooths out emotional peaks and valleys

'Meprospan'-400 brand of meprobamate contains 400 mg. in sustained-release form. One capsule smooths out the anxious patient's emotional peaks and valleys for 10 to 12 hours – and provides these other advantages:

1. **Especially suitable for maintenance therapy.** Patients whose anxiety has diminished to a mild or moderate level still require a certain amount of tranquilization throughout the day. Sustained-release action is ideally suited to this type of patient.

2. **Simpler dosage schedule.** Since one capsule of 'Meprospan'-400 (meprobamate, sustained release) acts 10 to 12 hours, the patient enjoys a much simpler dosage schedule than with tablets – and is less likely to forget to take the medicine.

Side Effects: Rarely, skin reactions. May increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence in patients with history of drug or alcohol addiction.

Available: *'Meprospan'-400* (meprobamate, sustained release) contains meprobamate 400 mg. *'Meprospan'-200* (meprobamate, sustained release) contains meprobamate 200 mg. Both potencies in bottles of 30. **Usual dosage:** One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Meprospan®-400
meprobamate 400 mg.
sustained release

CME-9188

ORGANIZATION SECTION

Cooperation Urged During Diabetes Detection Drive

All members of the Kentucky State Medical Association are urged to participate in the 1963 Diabetes Detection and Education Drive by Robert S. Tillett, M.D., Louisville, Chairman of the KSMA Diabetes Committee. This thirteenth annual drive is being sponsored again this year by the KSMA in cooperation with the American Diabetes Association. It will be held the week of November 17-23 (see editorial on page 872).

A record number of counties have indicated that they will participate, although there are still some who have not sent in orders for free clinistix, according to Doctor Tillett. Chairmen of the county diabetes committees should order clinistix through the Kentucky State Medical Association, 3532 Janet Avenue, Louisville, Kentucky, 40205.

All Kentucky physicians are asked to take part in the program and check urine samples free for the week of the Drive. County chairmen are requested to make complete reports following the drive to the KSMA Headquarters Office.

In 1962 approximately 62,772 free tests were made and 179 proved cases were reported. Approximately 2,000 previously unknown diabetics have been found since the first drive was held in 1951.

Other members of the KSMA Diabetes Committee are: Esten Kimbel, M.D., Frankfort; Sidney Brooks May, M.D., Eminence; Frank Moore, M.D., Bowling Green; and Cordell Williams, M.D., Hazard.

7,000 Registrants Expected At Portland AMA Meeting

More than 7,000 physicians and their guests are expected to attend the 17th Clinical Meeting of the American Medical Association to be held December 1-4 in Portland, Oregon.

Practical approaches to every-day problems in adolescent patients will be featured during one symposium on the scientific program. Among the other subjects to be discussed will be heart and blood vessel surgery, peptic ulcer, anemia, obstetrics and gynecology, smoking in relation to mortality and morbidity, and causes of death in automobile accidents, as well as many others.

Authorities in many specialty fields will gather in Portland to participate in the scientific program. Nearly all of the sessions will be held in the city's new Memorial Coliseum, and scientific and technical exhibits will be shown there.

Rural Health Conference Program Given

The Honorable Bert T. Combs, governor of Kentucky, and George P. Archer, M.D., president of the Kentucky State Medical Association will be among the speakers addressing the Eleventh Annual Kentucky Rural Health Conference at Jenny Wiley State Park, Prestonsburg, on October 24.

"Adequate Health Services and Facilities for Community and Area Development" is the theme of the program sponsored by the Kentucky Rural Health Council.

The morning session will include the following presentations:

"A Program of Area Development for Kentucky" —G. W. Schneider, Ph.D., associate director of the University of Kentucky Extension Service and chairman of the Kentucky Development Committee.

"A Profile of Health Services, Resources, and Needs in the Northeastern Kentucky Region"—Participants representing their respective groups: Physicians, Charles C. Rutledge, M.D., Hazard; Dentists, Lee Moore, D.M.D., Whitesburg; Pharmacists, Russell Johnson, Pikeville; Public Health Services, Russell Hall, M.D., Prestonsburg; Community Water Systems and Sewage Disposal, Ralph C. Pickard, Frankfort; Nurses, Mrs. Lola Belle Blair, R.N., Morehead; and Hospitals, Eugene Lopez, Pikeville.

"Community Approaches to Health as Part of a Total Development Program"—A Panel. Participants: Chairman, Robert L. Johnson, director of State and Community Services, U.K. Medical Center; William Hambley, M.D., mayor of Pikeville; O. T. Dorton, chairman of The Big Sandy Area Development Council; Maurice M. Hall, M.D., representing the Paintsville Chamber of Commerce.

Governor Combs will address the luncheon session, presided over by James C. Salato, M.D., Columbia, chairman of the Kentucky Rural Health Council.

After lunch, discussion groups will meet for an hour. "I Challenge You" will be the topic of Doctor Salato's talk at 2:30, following which the group will adjourn for a tour of Prestonsburg's new water and sewage plants.

Presiding at the morning session will be Roy Penix, Inez, area health educator. General chairman of the afternoon session will be William Padon of the Kentucky Farm Bureau Federation and secretary of the Kentucky Rural Health Council. Physicians wishing to attend the one-day meeting should make their room reservations for the night of October 23 through the KSMA Headquarters office.

Journal Staff To Participate In Chicago SMJAB Conf.

Walter S. Coe, M.D., Louisville, associate editor of The Journal of the Kentucky State Medical Association, will moderate a panel on "The Editor and His Contributors", to be presented during the 1963 State Medical Journal Conference in Chicago October 21 and 22.

"Your State Medical Journal and The Challenge of Change" will be the theme of the two-day meeting, sponsored by the State Medical Journal Advertising Bureau. J. P. Sanford, managing editor of The Journal of KSMA, is conference chairman.

Eight panel discussions on a variety of problems confronting medical editors will be presented by medical, pharmaceutical and journalism authorities from all sections of the United States.

Sam A. Overstreet, M.D., editor of The Journal, and Mrs. Harry Huntsman, assistant managing editor, will also attend the meeting. Approximately 150 editors and staff members of state journals are expected to register for the conference.

Farm-City Week Scheduled For November 22-28

KSMA members are urged to participate in the 1963 Farm-City Week program to be held in Kentucky November 22-28. Once a year this special week is set aside to help create a better understanding between farmers and city dwellers.

Many activities are scheduled across the state to help foster this relationship. Tours of farms are conducted for the urban population while the farmer is invited to visit industrial plants in nearby cities. Both segments of our population have problems of which the other is unaware. Therefore, Farm-City Week was established to better inform each of the existing problems.

N. Lewis Bosworth, M.D., chairman of the KSMA Council on Communications and Public Service, urges you to participate in the activities of Farm-City Week in your community so that you might better understand our farmer friends and their problems.

New Records In Mental Health

Several new records were set in the Kentucky Department of Mental Health during the past year, according to Mental Health Commissioner Harold L. McPheeters, M.D.

During the fiscal year 1962-63, the department registered 4,972 patients admitted to the four state Mental hospitals—the largest number of admissions in history. Of these, 2,750 were readmissions; 2,222 were first admissions. The resident population in the four hospitals dropped from 5,859 in June, 1962, to 5,453 in June, 1963. During the year there were 2,449 direct discharges, an increase of 6.3% over last year.

Fall Clinical Conference Program Released

"The Story of Hypertension" will be the subject of an address by Irvine H. Page, M.D., Cleveland, Ohio, featured guest speaker at the Eighth Annual Fall Clinical Conference, to be held in Lexington November 6. The one-day seminar is sponsored by the Lexington Clinic and the Kentucky Academy of General Practice.

Leslie W. Blakey, M.D., program chairman, said that the clinical conference has been approved by the American Academy of General Practice for seven hours Category I Postgraduate Credit. Doctor Blakey released the following full program:

Wednesday, November 6, 1963

9:00 a.m. Registration

Welcome—Harry U. Whayne, M.D., President, Kentucky Academy of General Practice.

Seminar on Rheumatoid Arthritis

Moderator: W. E. Herrell, M.D.

Clinical Aspects—C. R. Gill, M.D.

Juvenile Rheumatoid Arthritis—J. L. Chamberlain, M.D.

Laboratory Procedures—Albert Balows, Ph.D.

Roentgenographic Features—R. C. Quillin, M.D.

Intermission

Surgical Aspects—E. Q. Parr, M.D.

Physical Therapy—Don Lange, L.P.T.

Complications of Steroid Therapy—J. B. Selby, M.D.

The Story of Hypertension

Irvine H. Page, M.D., Division of Research, Cleveland Clinic Foundation

Luncheon With Round Table Discussion

2:00 p.m. Seminar on Specialized Diagnostic Techniques

Moderator: A. L. Cornish, M.D.

The Electroencephalogram—L. W. Blakey, M.D.

Mamography—Harold Rosenbaum, M.D., professor of radiology, University of Kentucky College of Medicine.

Pulmonary Function Tests—K. C. Tufts, M.D.

Telephonic Electrocardiography—J. A. Orr, M.D.

Intermission

Angiography—R. D. Floyd, M.D.

Blind Biopsies of the Gastrointestinal Tract—D. H. Johnston, M.D.

Special Hematologic Preparations—W. O. West, M.D.

Discussion

The 1964 meeting of the American Thoracic Society, medical section of the National Tuberculosis Association, will be held in New York City next May. Papers to be presented will be selected from abstracts submitted before January 6, 1964. Information concerning the submission of abstracts may be obtained by writing to the National Tuberculosis Association, 1790 Broadway, New York 19, New York.

Pharmacists Elect Danville Man

R. W. Leake, Danville, was elected president of the Kentucky Pharmaceutical Association at the July 24 meeting of the association in Lexington. He succeeds Jesse M. DeJarnette, Lexington.

KSMA Membership Roster At All-Time High

One of the top objectives of the 1962-63 KSMA President, David M. Cox, M.D., Louisville, was to analyze our membership roll and to increase membership in the county-state and AMA.

Testifying to the success of his leadership, membership in the KSMA is now at an all-time high. This is also true of Kentucky physicians holding membership in the AMA.

In sixty-five counties all physicians are members of KSMA. In thirty-nine of these counties all physicians are members of AMA. The report below will show that an additional twenty-five or thirty counties could have 100% membership if one or two physicians became members.

Number of Active Physicians in Kentucky Counties Who are Members of KSMA and AMA

(September 20, 1963)

COUNTIES	ACTIVE PHYSICIANS	MEMBERS KSMA	MEMBERS AMA
Adair	8	7	6
Allen	5	4	4
Anderson	4	3	1
Ballard	5	4	4
Barren	25	24	23
Bath	4	3	1
Bell	31	22	21
Boone	12	10	9
Bourbon	14	13	7
Boyd	51	50	50
Boyle	21	18	16
Bracken (*) (**)	3	3	3
Breathitt (*) (**)	3	3	3
Breckinridge	6	4	4
Bullitt (*) (**)	5	5	5
Butler (*) (**)	2	2	2
Caldwell (*) (**)	6	6	6
Calloway (*) (**)	14	14	14
Campbell	60	56	52
Carlisle (*) (**)	2	2	2
Carroll	6	5	5
Carter (*)	6	6	4
Casey (*) (**)	4	4	4
Christian	37	31	30
Clark	11	10	9
Clay (*)	6	6	5
Clinton	4	3	3
Crittenden (*) (**)	2	2	2
Cumberland (*) (**)	1	1	1
Davies	67	65	63
Edmonson (*) (**)	3	3	3
Elliott (*) (**)	1	1	1
Estill (*) (**)	4	4	4
Fayette	311	250	227
Fleming (*)	4	4	2
Floyd	21	9	8
Franklin	32	30	29
Fulton (*)	11	11	10
Gallatin (*)	1	1	0
Garrard (*) (**)	3	3	3
Grant (*) (**)	4	4	4
Graves (*) (**)	15	15	15
Grayson	6	5	0
Green	4	3	3
Greenup (*) (**)	8	8	8
Hancock (*) (**)	1	1	1
Hardin	26	24	21
Harlan	37	34	34
Harrison (*)	9	9	6
Hart (*) (**)	5	5	5
Henderson	23	21	21
Henry (*) (**)	5	5	5
Hickman (*) (**)	3	3	3
Hopkins (*)	32	32	31
Jackson	2	1	1
Jefferson	796	718	652
Jessamine (*)	6	6	3
Johnson (*) (**)	11	11	11
Kenton	100	85	79
Knott (*) (**)	3	3	3
Knox	8	7	3
Larue (*)	4	4	2
Laurel (*)	11	11	9
Lawrence	8	6	6
Lee	2	1	1
Leslie	2	0	0
Letcher	20	6	5
Lewis	3	2	2
Lincoln (*) (**)	3	3	3
Livingston (*)	4	4	1
Logan (*) (**)	11	11	11
Lyon (*) (**)	3	3	3
McCracken	51	50	49
McCreary (*) (**)	3	3	3
McLean (*)	4	4	0
Madison	27	26	24
Magoffin (*)	1	1	0
Marion (*) (**)	10	10	10
Marshall	10	8	8
Martin	1	0	0
Mason (*)	12	12	8
Meade (*)	3	3	2
Menifee (*) (**)	1	1	1
Mercer (*)	12	12	11
Metcalfe (*) (**)	2	2	2
Monroe (*) (**)	7	7	7
Montgomery	8	6	6
Morgan	6	4	3
Muhlenberg (*)	12	12	11
Nelson	9	8	8
Nicholas (*)	3	3	0
Ohio (*)	5	5	4
Oldham	7	6	6
Owen (*) (**)	3	3	3
Owsley (*) (**)	2	2	2
Pendleton (*)	4	4	1
Perry	24	14	14
Pike	38	25	23
Powell (*)	2	2	0
Pulaski	30	28	27
Robertson	1	0	0
Rockcastle (*)	2	2	0
Rowan	8	7	7
Russell	6	5	4
Scott (*)	9	9	4
Shelby (*)	9	9	8
Simpson	6	4	2
Spencer	5	2	2
Taylor	9	8	7
Todd (*) (**)	3	3	3
Trigg (*) (**)	3	3	3
Trimble (*) (**)	2	2	2
Union (*) (**)	5	5	5
Warren	38	36	36
Washington (*) (**)	5	5	5
Wayne (*)	6	6	5
Webster (*) (**)	5	5	5
Whitley	21	18	17
Wolfe (*) (**)	2	2	2
Woodford	9	7	3
TOTAL	2442	2152	1951

* 100% KSMA ** 100% AMA

Note: Report includes teaching staffs at medical schools, physicians in Public Health, Mental Institutions, T.B. Hospital, VA Hospital, etc.

U. of L. Professors Author Books Recently Released

Benjamin B. Jackson, M.D., associate professor of surgery, and David H. Neustadt, M.D., instructor in medicine, both at the University of Louisville School of Medicine, are the authors of medical books recently released by Charles C. Thomas, Inc., Publisher, Springfield, Ill.

"Chemistry and Therapy of Collagen Diseases", by Doctor Neustadt, and "Occlusion of the Superior Mesenteric Artery", by Doctor Jackson, are currently being reviewed for *The Journal's* Book Review page.

Both books, released just this summer, are a part of the American Lecture Series.

U.L. to Build Research Center For Child-Psychiatry

A child-psychiatry research center will be constructed by the University of Louisville as a first step toward establishing a mental-health center for children.

The $230,000 estimated cost of the center will come partly from a $114,257 grant from the National Institutes of Health, according to Doctor Philip Davidson, president of the university. The rest is to come from funds collected locally.

Future plans call for the construction of a new child-guidance clinic adjacent to the research building, and a small in-patient facility. John Ice, M.D., director of the Child Guidance Clinic at U. of L., will be medical director of the center.

blood, milk and Maalox® (magnesium-aluminum hydroxide gel)

Practically standard treatment, now, for bleeding ulcer. Why is Maalox included? Antacid therapy *must* continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good; it's effective and will not cause constipation — three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)

RORER

WILLIAM H. RORER, INC., FORT WASHINGTON, PA.

A POTENT antitussive and expectorant (without sugar)

TOLU-SED®

(For prompt relief of a wide variety of coughs, including those associated with colds, bronchitis, throat irritations, influenza, asthma, smoking, smog, dust irritation, and excessive use of the voice.)

EACH FLUID OUNCE CONTAINS:

64.8 mg.	CODEINE PHOSPHATE*—For its well-known actions in suppressing unnecessary and nonproductive coughs, AND to decrease the viscosity of sputum.
6 mg.	CHLORPHENIRAMINE MALEATE—To correct those allergic components which may be due to histamines. (The antihistaminic may contribute the usefulness of this preparation if locally released histamine plays a role in the process which causes the bronchial irritation.)
600 mg.	GLYCERYL GUAIACOLATE—To increase the fluidity of respiratory tract secretions. This action decreases the irritating effect of inspissated mucus and facilitates its removal.
2.5 gr.	TOLU—Because Tolu has been found useful on an empirical basis for coughs of diverse etiology.
2 min.	CHLOROFORM

***Contraindications:**

Codeine phosphate may be habit forming. In very large doses it may depress respiration.

Availability: Pints and Gallons

Administration and Dosage:
For Adults: 1 teaspoonful which may be repeated every 3 or 4 hours.

For Children over 6 years of age: ½ teaspoonful every 4 hours if necessary.

DALLAS • ATLANTA • SINCE 1901

Doctor Dock Guest Speaker At 1963 Norton Seminar

William Dock, M.D., nationally known internist, lecturer and medical writer, will be the guest speaker of the sixth Annual Norton Memorial Infirmary postgraduate medical seminar, to be held December 19 in Louisville. The day-long program will be co-sponsored by the Kentucky Academy of General Practice.

Now professor of medicine at the State University of New York's Downstate Medical Center in Brooklyn, Doctor Dock is a former associate professor of medicine and pathology at Stanford University and a former professor of pathology at Cornell. He received his M.D. from Rush Medical College in Chicago in 1923.

Doctor Dock was certified by the American Board of Internal Medicine in 1945. He is a Fellow of the American College of Physicians, and a member of the Association of American Physicians, the American Society for Clinical Investigation, the American Heart Association, the American Association of Pathologists and Bacteriologists, the Harvey Cushing Society, and the American Heart Association.

Doctor Dock will address the assembly in accordance with a new pattern established last year of inviting one guest speaker to the seminar. All other participants in the program are members of the staff of the University of Louisville College of Medicine.

The full roster of speakers and their topics follows:

Treatment of Urinary Tract Infections—Lonnie W. Howerton, M.D., assistant clinical professor of urology.

Use and Abuse of Antibiotics in Pediatric Therapy—Kenneth P. Crawford, M.D., assistant clinical professor of pediatrics.

Hormone Versus Surgical Therapy for Endometriosis—Laman A. Gray, M.D., clinical professor of obstetrics and gynecology and associate in pathology.

Gas-Gangrene of the Abdominal Wall—George B. Sanders, M.D., clinical professor of surgery.

Disturbances of Cardiac Rhythm: Current Methods of Therapy—Walter S. Coe, M.D., associate clinical professor of medicine and vice-chairman, department of medicine, and H. V. Noland, M.D., clinical professor of medicine.

The Use of Marlex Mesh in the Repair of Inguinal Hernias: Henry S. Collier, M.D , clinical instructor in surgery, and R. Arnold Griswold, M.D., clinical professor of surgery.

Mysterious Diseases of Connective Tissue—William Dock, M.D., professor of medicine, State University of New York College of Medicine.

Therapy With the Newer Progestational Agents—John D. Gordinier, M.D., assistant clinical professor of obstetrics and gynecology.

Tendon Tunnel Trouble—William T. Rumage, Jr., M.D., assistant clinical professor of surgery.

Immediate Ocular Therapy—Arthur H. Keeney, M.D., associate clinical professor of ophthalmology.

Treatment of Tuberculosis—Grover B. Sanders, M.D., clinical professor of surgery and assistant clinical professor of medicine.

The Doctor's Treatment of Misunderstood Youth—E. E. Landis, M.D., professor of psychiatry.

Therapy of Subdeltoid Bursitis—K. Armand Fischer, M.D., clinical professor and chief of section on orthopedic surgery.

Management of Coronary Obstruction—William Dock, M.D., professor of medicine, State University of New York College of Medicine, Brooklyn, N. Y.

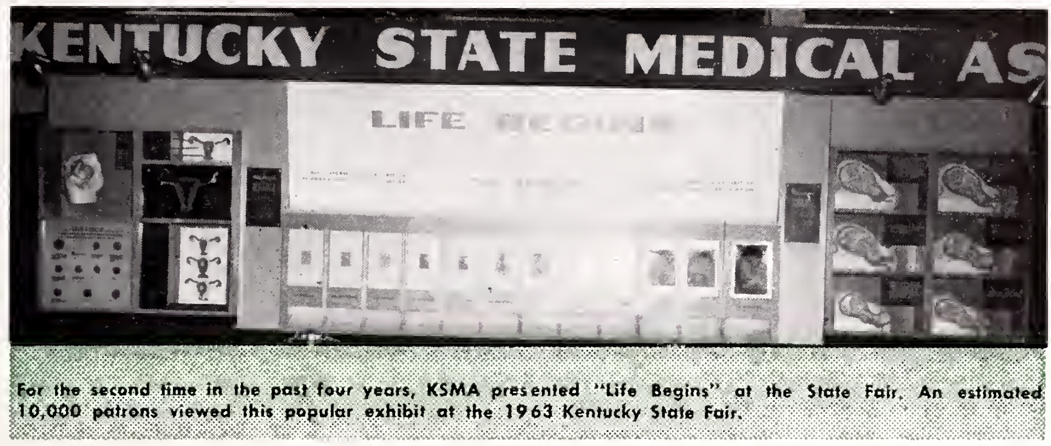
James W. Davis, M.D., vice speaker of the Congress of Delegates of the Kentucky Academy of General Practice, will open the session and describe the aims of the seminar.

Harry U. Whayne, M.D., Murray, president of the KAGP, will preside at the morning session. Presiding in the afternoon will be Harry S. Collier, M.D., president of the Norton staff.

Fred C. Rainey, M.D., Elizabethtown (Right), President of the Kentucky Junior Chamber of Commerce, receives the keys to a new buick from Mr. R. U. Fedderson, Assistant Zone Manager, Buick Motor Division, Cincinnati. During his tenure of office as Jaycee President, The Buick Division of General Motors Corporation replaces each Buick it furnishes Doctor Rainey at the end of every 5,000 miles of travel.

Ky. Physicians Named

Kurt Deuschle, M.D., director of the department of community medicine at the University of Kentucky, and William H. Anderson. M.D., director of the new Pulmonary center at the University of Louisville School of Medicine, have been named to committees of the American Thoracic Society. Doctor Deuschle is a new member of the editorial board of *The American Review of Respiratory Disease*, and Doctor Anderson has been named to the committee on medical education.



For the second time in the past four years, KSMA presented "Life Begins" at the State Fair. An estimated 10,000 patrons viewed this popular exhibit at the 1963 Kentucky State Fair.

Health-O-Drama Featured At Kentucky State Fair

Again this year, KSMA participated in Health-O-Drama along with a number of other interested groups. Telling the story of Kentucky's vital health services, Health-O-Drama completed its second "Tour of Duty" at the 1963 Kentucky State Fair.

Organized in 1962 by the Council on Allied Medical Services, Health-O-Drama is now known as the "Health Fair" within the State Fair.

KSMA's booth consisted of a 20-foot exhibit telling the story of how "Life Begins." Actual fetuses imbedded in plastic demonstrated the growth of the fetus from 4½ weeks through the 9th month. (See picture). One of the most popular exhibits at the Fair, "Life Begins" attracted some 10,000 viewers.

Health-O-Drama is designed to present to the people of Kentucky some of the measures being taken to protect their health and to educate the people to become more health minded. Again this year, free tests and medical services were included in some of the exhibits.

Governor Proclaims Oct. 20-26 Community Health Week

Governor Bert Combs has proclaimed October 20-26, 1963, Community Health Week in Kentucky in keeping with the first nation-wide observance of this program which was adopted by resolution at the AMA House of Delegates Meeting in November, 1962.

The objective of this national program is to focus public attention, at the community level, on the progress of medical science in all communities and the high quality of each community's health resources and facilities.

In proclaiming Community Health Week, Governor Combs called upon the Kentucky State Medical Association and Allied Health Professions, civic organizations and public schools to join in its observance to demonstrate to the people of Kentucky the many health services and facilities that enrich their lives and to encourage community planning to meet their needs of the future.

Community Health Week is a reminder to make certain that the high standards of health protection and services enjoyed today would be adequate to the needs that will arise in future years. Such activities as health fairs, science fairs, immunization campaigns, and orientation of students about medical and health careers can well be focal points around which community services and publicity can be organized.

Indiana Renews Reciprocity

Kentucky physicians again may practice in Indiana without taking the Indiana licensing examination, according to a recent announcement by the Indiana Licensing Board. Now that Kentucky has provided Indiana with the questions and answers to its state board examination, reciprocity, which was cut off early this year, has been restored. Indiana law prohibits the delegation of its testing authority to any other organization.

The American Epilepsy Federation will hold its annual meeting in Evansville, Ind., on October 31 and November 1, in conjunction with the first Midwestern Institute on Epilepsy. The scientific program will feature individual papers dealing with the pediatric, psychiatric, general medical, and neurosurgical aspects of epilepsy. For further information write to Philip T. White, M.D., Professor of Neurology, Indiana University Medical Center, 1100 W. Michigan St., Indianapolis 7, Indiana.

"Cardiovascular Drug Therapy" will be the theme of the Hahnemann Medical College and Hospital postgraduate course to be held January 20-23 at Marriott Motor Hotel, in Philadelphia. The purpose of the symposium is to evaluate the current cardiovascular armamentarium.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

Top Radiologist To Visit Kentucky November 8

Milton Elkin, M.D., wellknown radiologist from Yeshiva University, will speak on "The Effects of Drugs on the Appearance of Renal Vessels" for the Medical Grand Rounds at the University of Kentucky Medical Center Friday, November 8. Doctor Elkin is professor and chairman of the department of radiology at the Albert Einstein College of Medicine of Yeshiva University in New York.

"Radiologic Evaluation of Head Trauma With Emphasis on the Use of Cerebral Angiography" will be the topic of his address to the U. of K. X-Ray Department at noon the same day.

Doctor Elkin will also appear before a joint meeting of the Bluegrass Radiological Society and the Kentucky Radiological Society at the Sheraton Hotel in Louisville that evening. His subject will be "Renal Angiography."

In Kentucky

OCTOBER

17 — University Surgery Day, University of Kentucky, Lexington, Ky.

18-20 — Pediatrics Postgraduate Course, U. of L. School of Medicine, Children's Hospital, Louisville, Ky.

23 — Review of Current Problems in Obstetrical Anesthesia, U. of L. School of Medicine, Louisville General Hospital, Louisville, Ky.

24 — Rural Health Conference, Jenny Wiley State Park, Prestonsburg, Ky.

24-26 — Hematology Course, University of Kentucky, Lexington, Ky.

25 — Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

NOVEMBER

6 — Annual Fall Clinical Conference, Lexington Clinic, Lexington, Ky. Morning: Rheumatoid Arthritis; Afternoon: Specialized Diagnostic Techniques.

9 — Regional American College of Physicians, Holiday Inn, Lexington, Ky.

14-16 — Clinical Application of Newer Immunological Concepts, Department of Pediatrics, University of Kentucky, Lexington, Ky.

21 — University Surgery Day, University of Kentucky, Lexington, Ky.

29 — Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

DECEMBER

5-7 — The Family Physician's Role in the Pre and Post Operative Patient, Department of Surgery, University of Kentucky, Lexington, Ky.

19 — Annual Postgraduate Seminar, Norton Memorial Infirmary, Louisville, Ky.

19 — University Surgery Day, University of Kentucky, Lexington, Ky.

27 — Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

Surrounding States

OCTOBER

21-24 — Interstate Postgraduate Medical Association of North America, Chicago, Ill.

21-25 — Clinical Cardiopulmonary Physiology, American College of Chest Physicians, Chicago, Ill.

24-26 — Annual Course in Postgraduate Gastroenterology, American College of Gastroenterology, Shoreham Hotel, Washington, D.C.

28-Nov. 1 — American College of Surgeons, Brooks Hall, San Francisco, Calif.

NOVEMBER

6 — Gastroenterology, Indiana University, Indianapolis, Ind.

11-15 — American Public Health Association, Kansas City, Mo.

13 — Management of Diabetes Mellitus, Marion County General Hospital, Indianapolis, Ind.

13-14 — Advances in Internal Medicine, Cleveland Clinic Educational Foundation, Cleveland, Ohio.

18-21 — Southern Medical Association, Municipal Auditorium, New Orleans, La.

DECEMBER

1-4 — American Medical Association (Clinical Meeting), Memorial Coliseum, Portland, Ore.

10-12 — Southern Surgical Association, Hot Springs, Va.

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tension
headache

For comprehensive control of the whole pain complex...

Like a triad, the action of Trancogesic is direct and simple as 1,2,3. Its tranquilaxant component — chlormezanone — 1. reduces emotional reaction to pain . . . 2. decreases skeletal muscle spasm . . . and 3. its aspirin component dims the patient's perception of pain. Thus, Trancogesic controls the *whole* pain complex — *with unsurpassed tolerance.*

Each tablet of Trancogesic contains 100 mg. of chlormezanone and 300 mg. (5 grains) of aspirin. The usual adult dosage is 2 tablets of Trancogesic three or four times daily. Reactions to Trancogesic have been minor — gastric distress, and an occasional weakness, sedation or dizziness. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. Trancogesic is contraindicated in persons known or suspected to have an idiosyncrasy to aspirin.

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TRANCOGESIC*
CHLORMEZANONE with ASPIRIN
100 MG. 300 MG.
*TRADEMARK

Blue Cross in Ky. Celebrates Silver Anniversary

The Blue Cross Hospital Plan of Kentucky marked the 25th anniversary of its founding on August 1. The date also was the silver anniversary of D. Lane Tynes, executive director, who opened the first office.

Mr. Tynes

Blue Cross, then called "Louisville Community Hospital Service," was launched with $1,500 from each hospital and $3,000 borrowed from the Louisville Community Chest. During Mr. Tynes' tenure in office, the Plan has expanded from less than 14,000 in 1938 to 880,-322 by last April. During the 25-year period Blue Cross has become affiliated with Blue Shield, opened branch offices across the state, and established working relationships with similar plans throughout the nation, in Puerto Rico and Canada. In 1958 Blue Cross-Blue Shield moved to its present home office building on Bardstown Road.

The Journal offers its congratulations to both Mr. Tynes and the Blue Cross Hospital Plan for their combined service to the people of Kentucky.

MEDICAL SCHOOL NEWS

U. of L. Receives $63,855 In Gifts and Grants

A total of $63,855 was recently accepted by the Board of Trustees of the University of Louisville on behalf of several departments and individuals in the School of Medicine.

Mrs. Dann C. Byck, Louisville, will finance a $3,000-a-year pediatric residency program established at U. of L. and named in honor of her late husband. The first two years of the residency are to be taken in the U. of L. department of pediatrics; the third year at the Hospital for Sick Children in London, England.

According to Frank T. Falkner, M.D., chairman of the pediatrics department, the gift will mean that the university each year can attract top graduates interested in a pediatrics career.

Other Gifts and Grants

The National Science Foundation recently contributed $39,400 for continued support of research on "Cellular Respiration in the Developing and Aging Mammal" under the direction of Calvin A. Lang, Sc.D., department of biochemistry.

A grant of $5,000 from the Smith Kline and French Foundation was recently given to the University of Louisville department of physiology, headed by Warren S. Rehm, M.D. The funds will be used for graduate training for those seeking doctorates in biophysics and physiology, and for post-doctoral research.

In addition, the U. of L. Board of Trustees announced the acceptance of $3,500 from the Commonwealth Life Insurance Company, and a $500 bequest to the Medical School library from the estate of the late George A. Robertson, M.D. Mrs. Sidney I. Kornhauser presented the Medical Library with $100.

Other gifts and grants are as follows: Louisville Foundation, $6,155 for purchase of major equipment, and Kentucky Tuberculosis Association, $1,000 for minor equipment, both for the pulmonary disease section under the direction of William H. Anderson, M.D.; Mead Johnson & Company, $2,200 for study of activity of oil-suspended ferrous sulfate in nutritional microcytic anemias—Giovanni Raccuglia, M.D.; Simpson County Heart Association, $1,500 for the School of Medicine; and Abbott Laboratories, $1,500 for studies in respiratory diseases—William H. Anderson, M.D.

Television To Aid Studies

Televised patient interviews for freshman students will be a part of the revised curriculum starting this fall at the University of Louisville School of Medicine. In a plan to give students an earlier exposure to patients, two hours a week will be devoted to the closed-circuit interviews during the first semester. The course will expand to four hours for the spring session.

Doctor Waugh New Chairman Of Heart Research at UK

William H. Waugh, M.D., associate professor of medicine at the University of Kentucky college of Medicine, was recently named chairman of heart research at U.K.

The chair was established from $15,000 given to the university by the Kentucky Heart Association. This is part of $32,500 allocated to heart research by the association.

Doctor Waugh, who is also director of the renal section at the Medical Center, has been at U.K. since 1960. He is a 1948 graduate of Tufts College of Medicine.

Doctor Ray Receives Appointment

Edward H. Ray, Sr., M.D., has been appointed chief of the division of Urology at the University of Kentucky College of Medicine. Doctor Ray graduated in 1922 from Tulane University and did postgraduate work at the Mayo Foundation.

Albert L. Allen, M.D., Winchester, has become associated with the Clark County Hospital in Winchester and the Pattie A. Clay Memorial Infirmary in Richmond, for the practice of radiology. Doctor Allen, a 1933 graduate of the Medical College of the State of South Carolina, was a radiology resident at Duke University Hospital. A veteran of World War II, he previously practiced in North Carolina, West Virginia, and in Ashland, Ky.

News Notes

Milton M. Green, M.D., a member of the staff of Western State Hospital at Hopkinsville, has been named health officer for Henderson, Webster, and Union Counties, it was announced recently. Doctor Green began his new duties in September, replacing L. C. Brown, M.D., who resigned to study at Johns Hopkins University.

Jack L. Mulligan, M.D., former director of medical education at St. Joseph Infirmary in Louisville, has assumed his new duties as new director of the University of Kentucky's Health Service. He is a graduate of the University of Louisville School of Medicine and a native of Greenville.

J. W. Taylor, M.D., 84, Stamping Ground, was honored with a "Doctor Taylor Day" program held August 11 at the Stamping Ground School gymnasium. Doctor Taylor, a 1903 graduate of U. of L. School of Medicine, has practiced medicine in Owen and Scott Counties for 60 years, and still maintains an active practice. He is credited with having delivered nearly 3,500 babies.

George M. Gumbert, M.D., Lexington, was named vice-president of the Flying Physicians Association at the group's eighth annual meeting held recently in Aurora, Illinois. Doctor Gumbert will serve in the post for one year.

Malcolm H. King, M.D., Ashland, has become associated with **Hugh L. Ray, M.D.,** for the practice of anesthesiology. Doctor King received his M.D. from the University of Louisville School of Medicine in 1957, and interned at Louisville General Hospital prior to accepting a resident post at Cleveland Clinic Hospital, Cleveland, Ohio. From 1962-63 he was assistant staff anesthesiologist at Cleveland Clinic Hospital.

George G. Ellis, M.D., has entered into general practice in Williamsburg in association with **Raymond D. Sanders, M.D.,** and **Roemer D. Pitman, M.D.,** A 1962 graduate of the University of Louisville School of Medicine, Doctor Ellis interned at the Memorial Mission Hospital in Asheville, North Carolina.

William G. Begley, M.D., was recently stationed in Louisville, serving with the U.S. Navy. Doctor Begley, a general practitioner, received his M.D. from the University of Louisville School of Medicine in 1961, and completed his internship in 1962 at the U.S. Naval Hospital in Portsmouth, Va.

Ralph Robinson, M.D., has opened an office in Middlesboro for the practice of obstetrics and gynecology, it was announced recently. A native of Kansas, Doctor Robinson received his M.D. from the University of Washington School of Medicine in 1951 and interned at the University of Oklahoma. He previously was in private practice in Seattle, Wash.

Gertrude R. Holmes, M.D., has joined the staff of the Student Health Service at Berea College, according to a recent announcement. Doctor Holmes, a 1933 graduate of the Medical College of South Carolina, was previously in private practice in Greenville, South Carolina, and was on the staff of the Veteran's Administration Hospital in Dublin, Ga.

William H. Baker, M.D., has joined **James B. Douglas, M.D., Gerald M. Peterson, M.D., and Joan R. Hale, M.D.,** Heyburn Building, Louisville, for the practice of radiology. Doctor Baker, a 1959 graduate of the Indiana University School of Medicine, interned at King County Hospital in Seattle, Wash., before becoming a resident in radiology at the I.U. Medical Center.

Thomas S. Wallace, Jr., M.D., acting director of the Louisville-Jefferson County Health Department, has been granted a nine-month leave of absence to study for a master's degree in public health. **Alvin B. Mullen, M.D.,** will be acting director in his place. Doctor Mullen is tuberculosis-control officer and director of the tuberculosis clinic for the Health Department.

Thomas H. Baird, M.D. has entered into the general practice of medicine in Bowling Green. A 1958 graduate of the University of Louisville School of Medicine, Doctor Baird interned at Charity Hospital of Louisiana in New Orleans and was a resident in general practice at Huey P. Long Charity Hospital in Pineville, La.

25 New Members Added To KSMA Roster

Twenty-five physicians have recently become new members of the Kentucky State Medical Association.

This brings the membership total to 2,152 as of September 20, 1963. (See story and report on page 000).

The following are new members from Lexington: Lee C. Shine, M.D.; W. W. Adams, M.D.; H. J. Batts, M.D.; John H. Henderson, M.D.; Bush A. Hunter, M.D.; Henry Tesluk, M.D.; Frederick Eberson, M.D.; W. B. Snyder, M.D.; L. E. Wallace, M.D.; M. A. Carnes, M.D.; John L. Durhing, M.D.; Charles B. Wilson, M.D.

Other new members, all from Louisville, are: Irvin Bronner, M.D.; Harold J. Kosasky, M.D.; and Clarence Peters, M.D.

Recent additions from other parts of the state include: Thomas H. Baird, M.D., Bowling Green; Chris B. Foster, M.D., Glasgow; Imogene Gobble, M.D., Lakeland; Raymond E. Hayden, M.D., Barbourville; Charles D. Howard, M.D., Springfield; John O. Jones, M.D., Flatwoods; Mark A. Judge, M.D., Central City; B. J. Kidd, M.D., Brownsville; Arnold Taulbee, M.D., Campton; and Billy H. Wells, M.D., Albany.

In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient").*

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

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In Memoriam

BOYD V. BAKER, M.D.
Grayson
1886-1963

Boyd V. Baker, M.D., 77, Grayson general practitioner, died September 8, it was announced recently. Doctor Baker, who graduated in 1912 from the Lincoln Memorial University Medical Department in Knoxville, Tenn., had practiced in Hazard before moving to Grayson in 1957. He was said to have delivered more than 5,000 babies during his 50 years of practice.

R. W. BLEDSOE, M.D.
Covington
1873-1963

Robert W. Bledsoe, M.D., retired Covington ophthalmologist-otolaryngologist who celebrated his 90th birthday July 4, died suddenly August 26. Doctor Bledsoe received his M.D. from Miami Medical College in Cincinnati in 1900, and had been on the faculty of the University of Cincinnati School of Medicine.

PAUL S. YORK, M.D.
Glasgow
1902 - 1963

Paul S. York, M.D., Glasgow urologist and civic leader, died suddenly September 6 in Elizabethtown. Doctor York, a 1927 graduate of Vanderbilt University School of Medicine, was a past president of the Barren County Medical Society and active in KSMA. He was chairman of the Barren County School Board. Doctor York, a retired lieutenant colonel, was a veteran of World War II and an elder in the First Christian Church of Glasgow.

JOHN A. O. BRENNAN, M.D.
Louisville
1880 - 1963

John A. O. Brennan, M.D., 83, a long-time Louisville general surgeon, died September 1 at St. Anthony Hospital, where he had been a member of the staff for many years. He received his medical degree from the Medical Department of the University of Louisville in 1901, and studied in medical colleges in Vienna, Munich, Paris and London. An emeritus member of the KSMA, Doctor Brennan was also a member of the Jefferson County Medical Society, the AMA, and the International College of Surgeons.

HOWARD W. RIPY, M.D.
Lexington
1921 - 1963

Howard W. Ripy, M.D., 42, Lexington pediatrician, died unexpectedly at his home on Tuesday, September 3. A native of Lawrenceburg, Doctor Ripy graduated in 1945 from Vanderbilt University School of Medicine in Nashville. He was a veteran of World War II and the Korean War, and was a member and past secretary of the Kentucky Pediatric Society.

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.

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Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenol 0.25%; sodium carbonate as buffer.

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ANTITUSSIVE/DECONGESTANT/ANALGESIC 'EMPRAZIL-C'® TABLETS

Each tablet contains:

Codeine Phosphate* .... 15 mg.
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'Perazil'® brand Chlorcyclizine Hydrochloride..... 15 mg.
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Pertinent Paragraphs

"Newer Concepts in Clinical Pathology" will be the topic of the postgraduate course being offered October 30 and 31 by the Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio. Registration will be limited to 125; acceptances made in order of application.

The 16th Annual Meeting of the American Association of Blood Banks will be held November 5-8 at the Statler Hilton Hotel in Detroit, two days later than originally scheduled. The Association is an organization of community and hospital blood banks that collect, process and deliver more than 5,500,000 units of blood used each year in the United States.

The First Annual Postgraduate Seminar in Anesthesiology will be held in Miami Beach, Florida, on January 5-8 under the co-sponsorship of the University of Miami and the University of Florida Schools of Medicine. "The Cardiovascular System" will be the theme of the seminar, which will be of interest to all phases of medical practice. For additional information write Frank Moya, M.D., Professor and Chairman, Department of Anesthesiology, University of Miami School of Medicine, Jackson Memorial Hospital, Miami 36, Fla.

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Chromosomes and Clinical Practice

Continued from Page 852

Summary

Two cases are presented illustrating the applications of chromosomal studies to clinical practice. It is suggested that such studies are indicated clinically in four areas:

(1) Problems of sex determination.

(2) Problems of mental retardation, sterility, and menstrual irregularities.

(3) Genetic counseling.

(4) Search for new disease entities.

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John H. Burke, M.D., recently entered general practice in Lexington, where he will practice in association with **Robert M. Sirkle, M.D.** Doctor Burke, a 1941 graduate of George Washington University School of Medicine, is a veteran of World War II. Until recently he practiced in McDowell County, W. Va.

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News Items

John O. Jones, M.D., has begun general practice at Flatwoods, according to information recently received. Doctor Jones, who graduated in 1960 from the University of Louisville School of Medicine, interned at St. Elizabeth Hospital in Dayton, Ohio before joining the U.S. Air Force.

Charles B. Wilson, M.D., has joined the staff of the University of Kentucky Medical Center for the practice of neurosurgery. Doctor Wilson received his M.D. from Tulane University School of Medicine in 1954, and interned at Charity Hospital in New Orleans. He was a resident in pathology at the same hospital until 1956, and served a residency in neurosurgery at Ochsner Foundation Hospital in New Orleans. Before coming to Lexington Doctor Wilson was in practice in New Orleans.

William G. Malette, M.D., a graduate of Washington University Medical School, St. Louis, in 1953, is now on the staff of the Veterans Hospital, Lexington. He is limiting his practice to general and vascular surgery. Doctor Malette took his residency training at Denver Veterans Administration Hospital after completing his internship at Letterman Army Hospital. He served for 11 years in the U. S. Air Force Medical Corps, receiving his discharge with the rank of major.

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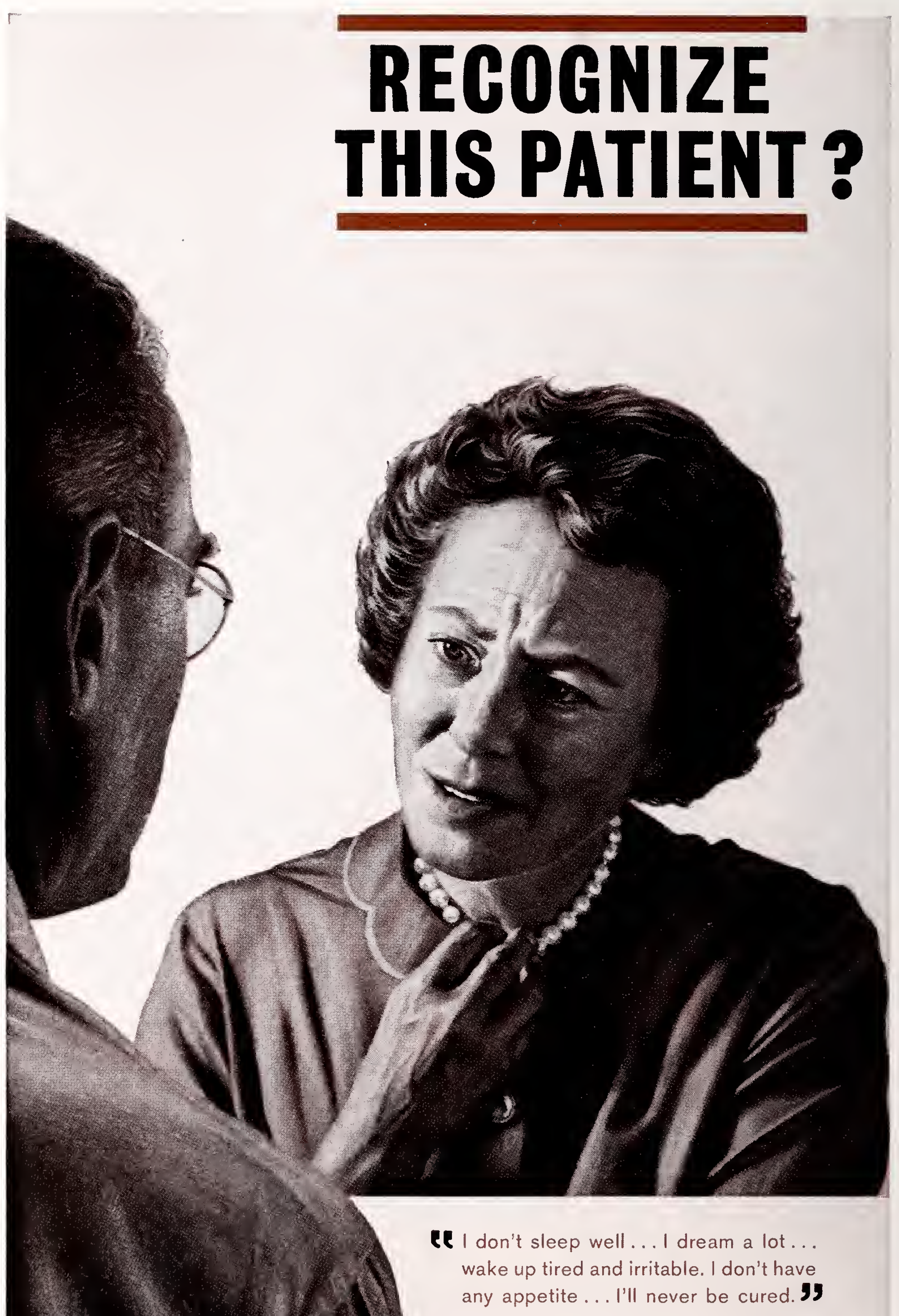
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Evaluation of Laboratory Techniques

(Continued from Page 857)

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James M. Chase, Jr., M.D. has recently become associated with **John M. Allen, M.D.** in Lexington for the practice of surgery. Doctor Chase is a 1956 graduate of the University of Maryland, interned at the Delaware Hospital, Wilmington, Delaware, and completed his residency at University Hospital, Baltimore, Maryland in 1961. Until 1963 Doctor Chase was Chief of Surgery of Castle Air Force Base, California. He received his certification by the American Board of Surgery in 1962.

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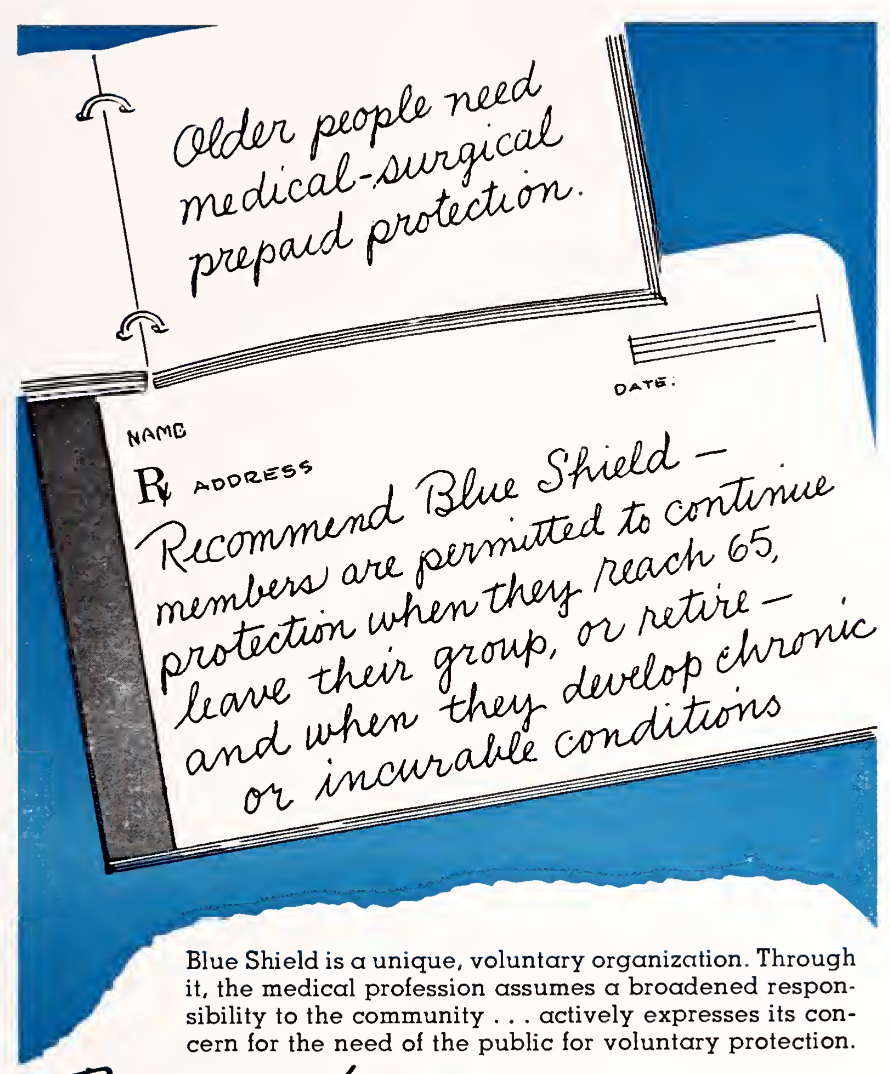

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STUDY OF MATERNAL MORTALITY

CASE #129—A 20 year old married, white gravida 2, para O, ab 1, was first seen by her private physician in the third month of pregnancy. The prenatal course is summarized in the following table:

Month of Pregnancy:	1	2	3	4	5	6	7	8	9 (1)	(2)	(3)	(4)
Blood Pressure			112/70	114/70	120/70	—	114/74	118/68	114/70	114/78	—	124/80
Weight			120	125½	128½	—	136½	142	144½	137	—	142
Urinalysis			Neg.	Neg.	Neg.	—	Neg	Neg.	Neg.	Neg.	—	Trace alb.

The patient was Rh negative, and her husband, Rh positive. Serology tests for syphilis were negative. The hemoglobin was determined on one occasion, and found to be 11 gm.

The past history was essentially negative. The patient had developed a urinary tract infection early in May, 1960, during her first pregnancy. The infection responded promptly to outpatient medical treatment. A previable infant was delivered on June 13, 1960. The expected date of delivery for the present pregnancy was June 26, 1961. The fetus lay in breech presentation throughout the third trimester. On June 19, a plain film of the abdomen showed a term-sized fetus in frank breech presentation.

On June 19, 1961, the patient went into labor spontaneously. The membranes ruptured at home at 6:00 a.m. and on admission to the hospital 30 minutes later, the patient was having good contractions at five minute intervals. The blood pressure was 118/82. Vaginal examination showed the presentation to be cephalic, and the cervix to be dilated to three fingerbreadths. At 8:30 a.m. the patient was given 75 mg of Demerol 50 mg of phenergan and ¾ of an ampule of Lorfan. The cervix was to four fingerbreadths. The fetus lay in ROP at station plus one. At 9:25 A.M. only an anterior lip of the cervix remained; the occiput was posterior. Contractions continued to be of quality and when complete dilation of the cervix had been attained and the head had descended to plus one station, the patient was taken to the delivery room and allowed to labor there; however, the occiput failed to rotate anteriorly. Several unsuccessful attempts were then made to rotate the occiput manually to an anterior position, following which a forceps rotation was done under drip ether anesthesia and delivery of a 7 pound-8 1/2 ounce infant was completed at 10:52 a.m. The intact placenta was delivered spontaneously at 10:55 a.m., three minutes after delivery of the baby.

The infant failed to breathe spontaneously for approximately four minutes, but responded satisfactorily after a brief period of external cardiac massage and intermittent positive pressure oxygen by mask. The color and respirations were good when the infant left the delivery room about thirty minutes later.

In addition to a left mesolateral episiotomy, the patient sustained a mid-line second degree laceration of the perineum. The patient appeared in good condition, and the blood loss was considered average for a normal delivery. Following the delivery of the placenta, 1cc of Methergine was given. Repair of the episiotomy and laceration was almost completed when the patient was suddenly noted to be pale and cyanotic, with rapid, shallow respirations. The pulse was thready and fast, and no blood pressure could be obtained. The fundus was quickly checked and was firmly contracted below the umbilicus; otherwise the abdomen was soft. There was only a slight trickle of dark blood from the vagina. Oxygen by mask was started immediately. An intramuscular injection of adrenalin was given, and an intravenous drip of neosynephrine was started. A cut-down was done on the right ankle, and 500 cc of 5% glucose in water with 7 cc of Levophed was started. Despite these measures no blood pressure could be obtained. Four units of Dextran and three pints of whole blood were given while a second cut-down was done on the left ankle, and 100 mg of Solu-Cortef was given intravenously. After several hours it was apparent a state of irreversible shock was present. External cardiac massage was instituted, although only a very feeble abdominal aorta pulse could be detected. No vital signs were detected over a 30 minute period, and the patient was pronounced dead at 3:10 p.m. The cause of death was stated to be circulatory collapse due to factors not immediately determinable, probably amniotic fluid embolus.

Comments:

The Committee classified this case as a direct obstetrical death apparently unpreventable. The diagnosis of amniotic fluid embolus was considered untenable in the absence of autopsy evidence of fetal squames in the lungs. An autopsy would also have determined whether or not massive intra-abdominal hemorrhage had occurred during the forceps rotation.

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Case Discussion

(Continued from Page 870)

obese patient to ventilate the patient more or less routinely for four to eight hours postoperatively by connecting the Mörch respirator to the endotracheal tube used during anesthesia. This supports the patient during the first few critical hours after operation and assures adequate ventilation until it is certain that all residual effects of anesthetics, muscle relaxants and narcotics given during operation have worn off. This appears to be a valuable means of preventing postoperative pulmonary complications.

David Y. Keith, M.D., Paducah, has opened an office in that city for the practice of psychiatry after completing his internship at Jackson Memorial Hospital in Miami, Fla. After receiving his M.D. from the University of Louisville School of Medicine in 1944, Doctor Keith interned at the U.S. Marine Hospital in Staten Island, N.Y., before serving two years in the United States Army. From 1948 to 1960 Doctor Keith was in general practice in Paducah.

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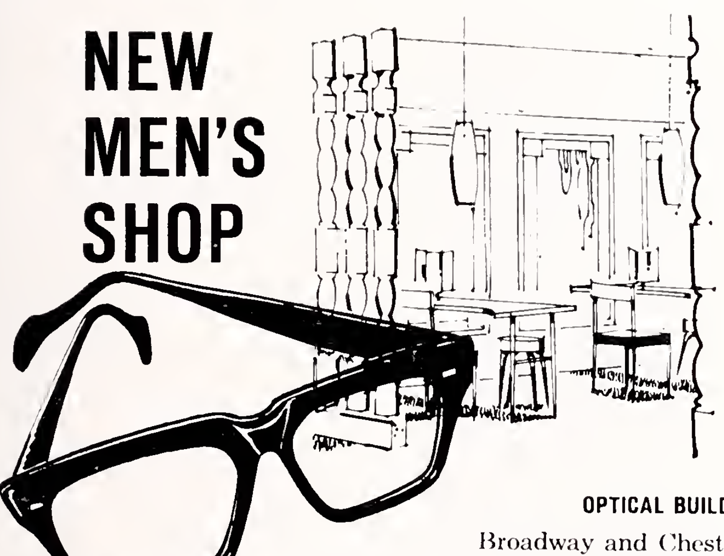

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Clinical Aspects of Adrenal Cortical Function

(Continued from Page 868)

function has been reviewed briefly. Details of the laboratory diagnosis and treatment of Cushing's syndrome are discussed. Brief case histories illustrate typical problems in the management of this disorder.

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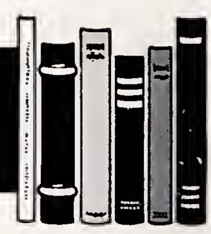

MODERN CLINICAL PSYCHIATRY: by Arthur P. Noyes, M.D., and Lawrence C. Kolb, M.D.; Sixth Edition, W. B. Saunders Company, Philadelphia, 1963; 586 pages; price, $8.00.

The new sixth edition of Noyes and Kolb *Modern Clinical Psychiatry* offers a useful text in general psychiatry for the student, house-officer and practitioner. As in past editions, the material is well written and organized; the format has been improved by dividing the pages into columns and more clearly labeling the sections and subsections.

This edition incorporates many of the ideas in the literature of the past five years. Revision and organization of the chapters in personality, theory and psychopathology incorporate new clinical and experimental findings in the area of social isolation and the effect of family interaction upon personality development and symptom formation.

The chapter on mental deficiency has been expanded and rewritten to incorporate a number of biochemical and cytogenic events resulting in defective brain development and later mental retardation.

The discussion of pharmacological therapy presents the current impression of the phenothiazine derivatives and other agents used in the treatment of the psychoses based upon a decade of experience. The initial flooding of the clinical market by new products has slowed sufficiently so that the efficacy of the major drugs in use today are objectively appraised. With each agent is listed dosage, physiological effects and side-effects. A section on the anti-depressant agents has been introduced and similarly presented. Unfortunately, in spite of enlargement the brevity of the chapter can offer only a scant survey of the subject which limits its usefulness.

Much material has been added on the brain syndromes associated with hepatolenticular degeneration, hepatic insufficiency, and headache syndromes—body image disorders, impotence, frigidity and menstrual disorders, reaction to abortions and sterilization.

The final chapter provides a clarifying discussion *Psychiatry and the Law* with a report on the British Mental Health Act.

Noyes and Kolb continues to be the leading American text on psychiatry.

Roswell Fine, M.D.

SYNOPSIS OF PEDIATRICS: by James G. Hughes, M.D.; published by C. V. Mosby Company, St. Louis, 1963; 1031 pages; price, $9.85.

This synopsis for the specialist, busy physician, and the resident has been developed to condense and crystalize important medical information. There are short, well written sections on growth and development, psychological aspects of childhood, mental retardation and infant feeding, well organized sections on fluids and immunization. The sections on the pediatric history and examination of the newborn, premature infant, on the digestive and respiratory systems are well written. There is a well organized comprehensive section on endocrine diseases. The sections on pediatric cardiology and hematology are easy to read. They are followed by a section on the urinary tract which is good but makes no mention of enuresis. There is no mention of virus influenza in the infectious disease section; otherwise this is a very good section.

The section on diseases of the nervous system includes no mention of the Holter valve procedure and hydrocephalus does not appear in the index of the synopsis. The appendix includes useful information including pediatric dosages and other material. This book provides a quick reference and should be particularly valuable to interns and residents and to any physician working with children.

R. D. Brooke Williams, M.D.

CLINICAL METABOLISM OF BODY WATER AND ELECTROLYTES: by John H. Bland, M.D.; published by W. B. Saunders Company, Philadelphia and London; 1963. 623 pages, price, $16.50.

This book represents a multi-authored description of metabolism of body water and electrolytes. It is a major advance over Dr. Bland's second edition (1956) in this field; many subjects are presented in a definitive, authoritative and up-to-date manner.

The first several chapters concern an orderly presentation of basic facts and concepts in the biochemistry, physiology, and applied field of water and electrolyte metabolism. Most of the following chapters deal with water and electrolyte aspects in specific areas of disease. These chapters should be of particular value to the advanced student or clinician.

Many important clinical and research contributions of the past few years are discussed, with citation of relevant references. This is an excellent feature of this book, in a field in which the literature is voluminous. Some chapters are outstanding in review coverage, for example Chapter 19 (by Cort) on neural relationships and Chapter 20 (by Mason) on shock. Chapter 13 (by Behnke) on electrolyte aspects related to aging is particularly timely.

Chapter 3 (by Christensen) on pH control should be difficult for many readers to grasp. The emphasis on hydrogen ion coupled with a neglect or under-emphasis on fixed and unfixed anions versus cations leads to poor comprehension of neutrality regulation. Clinical aspects of this problem are well covered in Chapter 8 (by Bland).

This book is highly recommended as an excellent reference book. Its bulk (623 pages) perhaps mitigates its general usefulness. However, it contains much of value for the practicing clinician and the pre- and post-graduate student of medicine.

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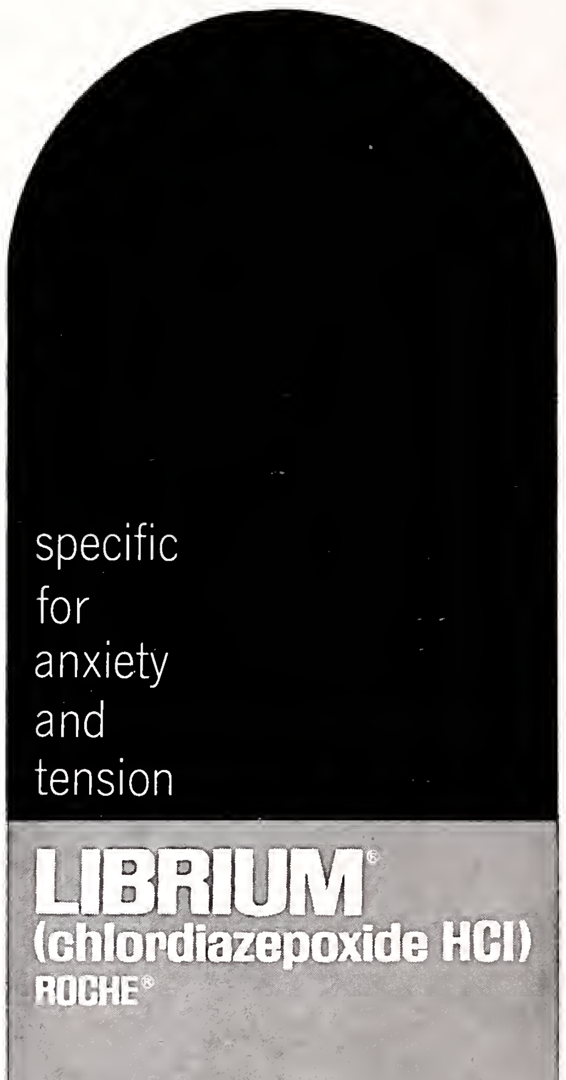

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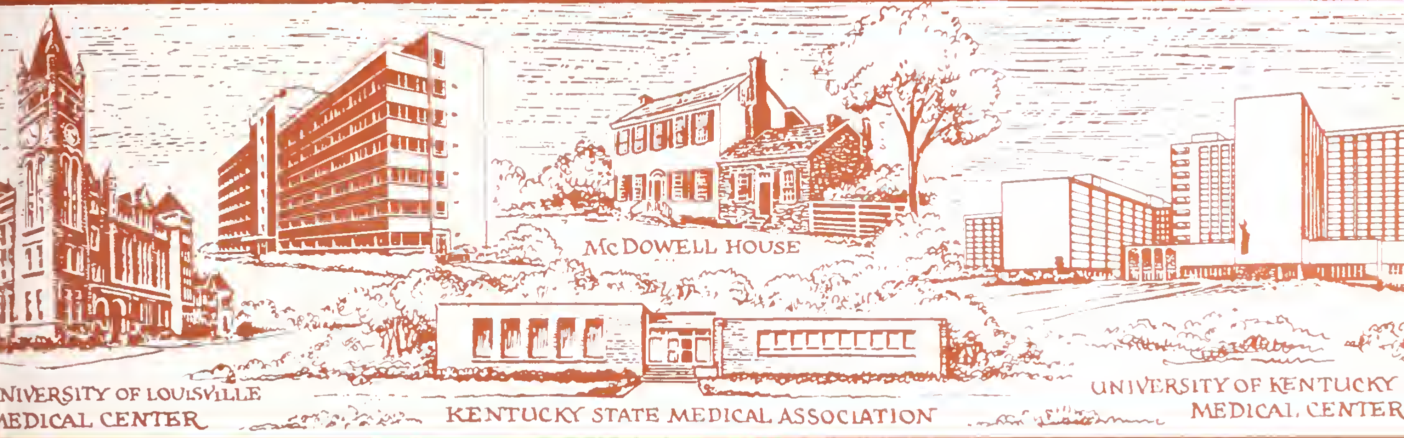

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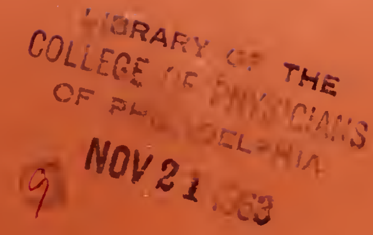
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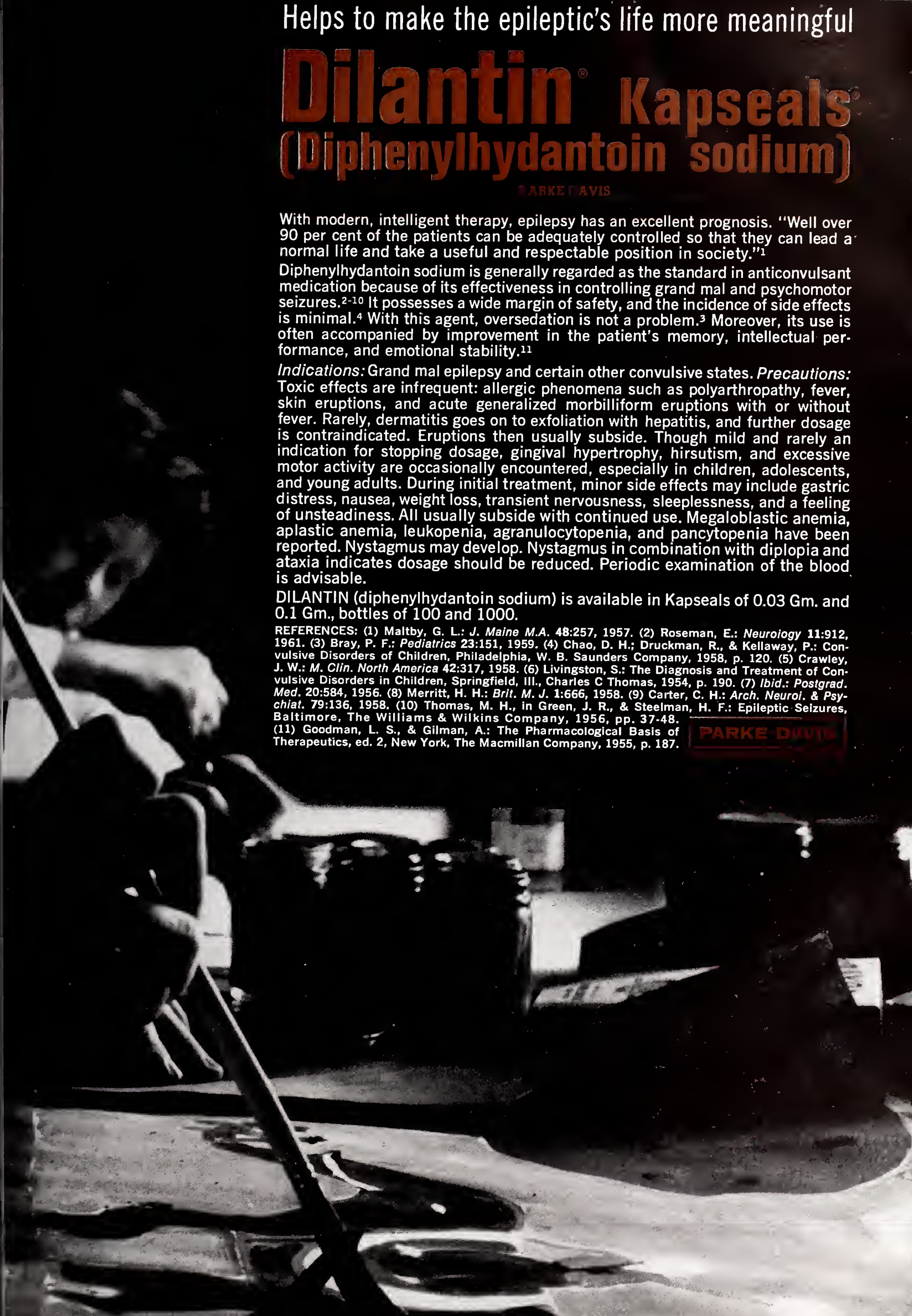
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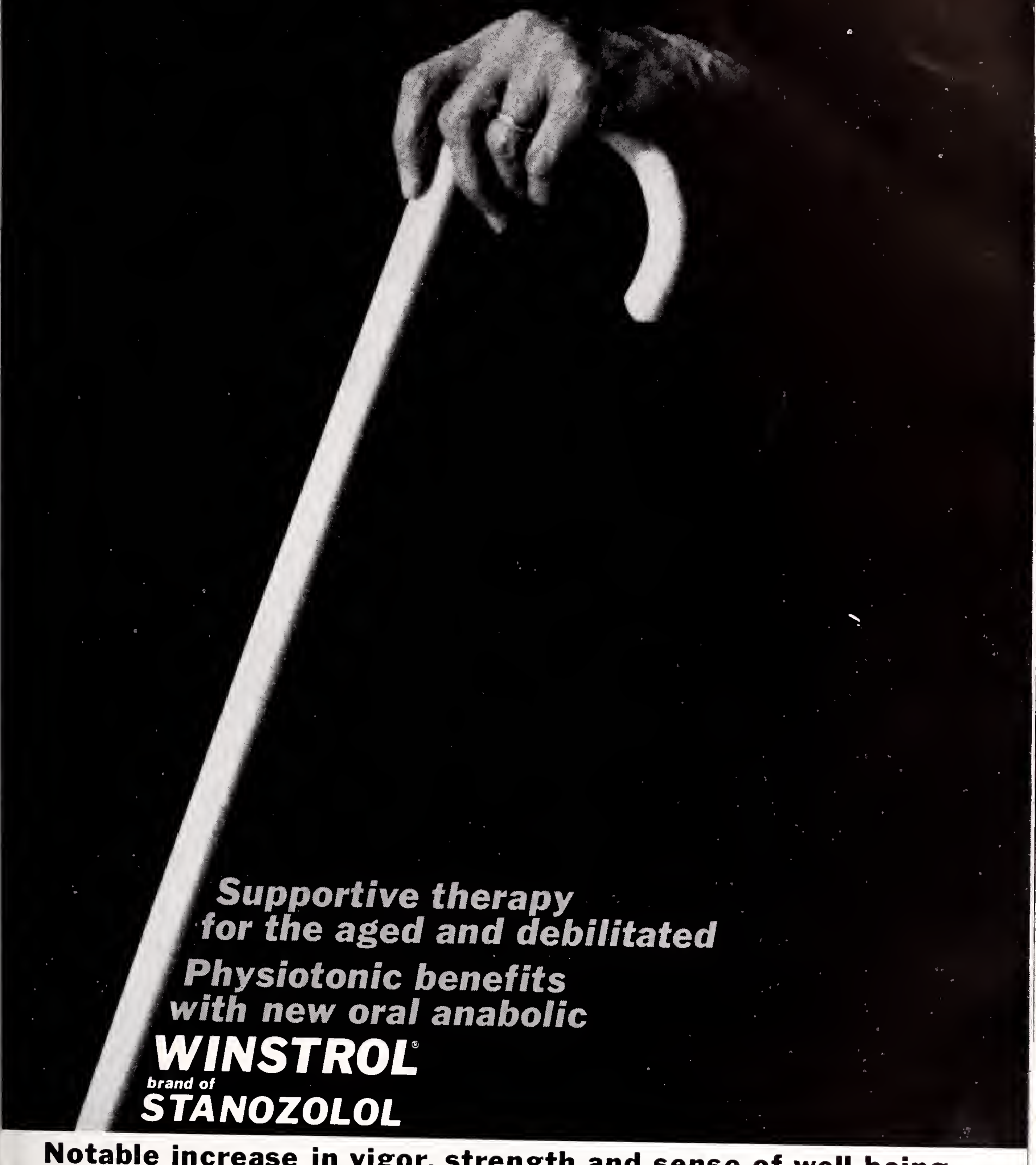

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Effects and Precautions: Prolonged administration can produce hirsutism, acne or voice change. In an occasional patient, edema een observed and in young women the menstrual periods have milder and shorter. These side effects are reversible, and pa- receiving prolonged treatment should be examined and ques- tioned periodically so that, should side effects appear, the dosage may be reduced or administration of the drug discontinued for a time. In patients with impaired cardiac and renal function, there is the pos sibility of sodium and water retention. Liver function tests may revea an increase in bromsulphalein retention, particularly in elderly pa tients. In such cases, therapy should be discontinued. Although it has been used in patients with cancer of the prostate, its mild androgenic activity is considered by some investigators to be a contraindication.

Dosage: Usual adult dose, 1 tablet t.i.d. before or with meals; young women, 1 tablet b.i.d.; children (school age): up to 1 tablet t.i.d.; chil- dren (pre-school age): ½ tablet b.i.d. Available as scored tablets of 2 mg. in bottles of 100. For best results, administer with a high protein diet.

WINTHROP LABORATORIES, NEW YORK 18, N. Y.

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MESSAGE FROM THE PRESIDENT

Operation Hometown

OUR new program, "Operation Hometown," has given us a framework within which our grass-roots campaign against the King-Anderson Bill can be waged effectively.

"Operation Hometown" is a nationwide intensive and continuing program of education to offset the mounting pressures for King-Anderson legislation in the 88th Congress.

This year or next may well see the beginning of the end of America's high health care standards and the freedom of the medical profession. The facts must be made known, and "Operation Hometown" provides the tools and techniques for our County medical societies to present them to our fellow citizens.

The progress which has been made in the implementation of the Kerr-Mills Law is another important point in medicine's favor today. This has been an area in which the state societies have made an outstanding record of progress. Despite formidable opposition by the administration, 37 states and four jurisdictions have put Kerr-Mills MAA programs in operation or enacted authorization legislation.

I wonder how many Kentucky doctors are trying to make Kerr-Mills work in Kentucky. I hope you can all truthfully answer, "I am pulling my weight."

George O. Archer M.D.

NAME

ADDRESS

℞

cut Rx writing by 2/3 in colds, flu or grippe

No need to write three separate prescriptions for antitussive, decongestant and analgesic relief of common cold, flu or grippe symptoms when it is therapeutically correct... economically sound...to specify

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'EMPRAZIL-C'® TABLETS

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Phenacetin	150 mg.
Aspirin	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming

'Emprazil-C' Tablets are available on prescription only.

Dosage: Adults and children over 12 years—1 or 2 tablets—3 times daily as required. Children 6 to 12 years—1 tablet—3 times daily as required. **Caution:** While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed. **Supplied:** Bottles of 100 tablets.

Also available without codeine as 'EMPRAZIL'® TABLETS

Complete literature available on request from Professional Services Dept. PML.

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Tuckahoe, N. Y.

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it's versatile: The years have proved that 'Miltown' (meprobamate) is the one tranquilizer that is helpful in almost every aspect of daily practice. Virtually any of your patients, regardless of age, can be given the drug with confidence, either as a primary treatment or as an adjunct to other therapy. **Outstanding record of safety:** Over eight years of clinical use among millions of patients throughout the world — plus more than 1500 published reports covering the use of the drug in almost every field of medicine — support your prescriptions for 'Miltown' (meprobamate). This is why it *"belongs in every practice."*

dependable: 'Miltown' (meprobamate) is an established drug. There are no surprises in store for you or your patient. You can depend on it to help your patients through periods of emotional distress — and to help maintain their emotional stability.

easy to use: Because 'Miltown' (meprobamate) is compatible with almost any other kind of drug therapy, you'll find it fits in easily with any program of treatment you are now using. It will not, therefore, complicate treatment of patients seen in clinical practice.

BRIEF SUMMARY: *Indications:* Anxiety and tension states, and all conditions in which anxiety and tension are symptoms. *Side Effects:* Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1-4 doses of the drug. *Contraindications:* Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. *Precautions:* Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities, to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available to physicians on request.*

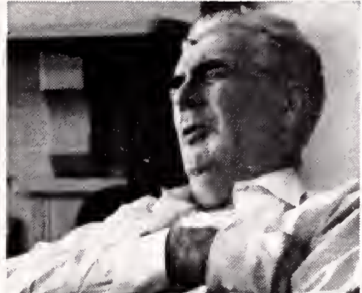
USUAL ADULT DOSAGE: 1 or 2 400 mg. tablets t.i.d.

SUPPLIED: 400 mg. scored tablets, 200 mg. coated tablets.

CM-9694

The insomniac

The tense, nervous patient

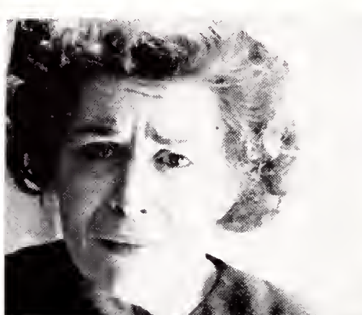

The heart-disease patient

The surgical patient

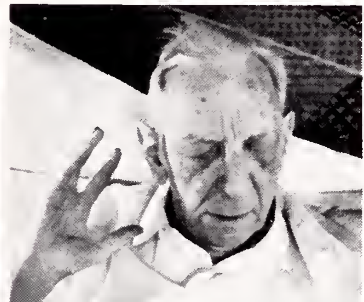
ıe girl with dermatosis

Tension headache

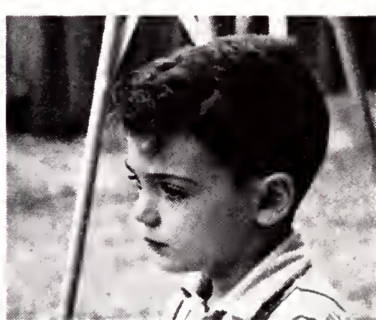
The woman in menopause


Anxious depression

'remenstrual tension


The agitated senile patient

The alcoholic


The problem child

The G.I. patient

the original brand of meprobamate

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THE INSURANCE PAGE

Are Hospital Costs Too High ?

IN A RECENT article in "Hospital Accounting", which was quoted in *Health Insurance Viewpoints,* Mr. Ernest C. Laetz, a past president of the American Association of Hospital Accountants, analyzed the key factors contributing to the cost of patient care in our hospitals.

He pointed out that everyone's hospital bill could be cut in half simply by eliminating such things as deep x-ray therapy and cobalt machines, expensive sterilizers, surgical microscopes, and all of the other complicated equipment found in modern hospitals; and at the same time reducing employees' salaries and lengthening their hours of work.

Today's hospital equipment saves lives, shortens hospital stays and contributes immeasurably to the comfort and welfare of the patient. And yet, this equipment helps boost the price of hospital care, and in time, the premiums for hospitalization insurance.

But this factor alone does not explain why hospital rates have increased to the point where currently it costs $40 to $50 a day to take care of an average patient, contrasted to $25 a day 10 years ago.

To better understand the reason for this upward push and to identify hospital costs, it was pointed out that hospital costs are composed of: salaries and wages, and supplies and equipment. The former represents 70 percent of costs and the latter 30 percent. This is in contrast to industry, where salaries are 28 percent of costs and the other expenses 72 percent. Analyzed, this means that hospitals sell service rather than products. Services come high, because their chief ingredient is salaries, not goods.

Whereas industry has been able to absorb increased cost through increased production, hospitals can increase production through mechanization only to an extremely limited extent, so that every round of salary increases constitutes a direct increase in hospital costs.

Even so, hospital wages lag behind industry; and if hospitals are to get the quality of workers they need, wages must continue to rise in order to be competitive with those of industry. Seldom, today, do we find dedicated people in the hospital who are willing to work for substandard wages.

Unless there is a significant decrease in the general economic situation, we must expect hospital costs to continue to increase about five percent annually. Even so, none of us wish to see the quality of medical care curtailed.

For most Americans, the answer to increased expenditures for medical care is prepayed health insurance. Today, three out of four persons, some 76 percent of the population, have some health insurance protection. Twenty years ago only 15 percent, or one out of seven persons, were so covered.

Health insurance benefit payments have risen at an even faster pace, attesting to the capabilities of insuring organizations to keep pace with the advances of modern medicine, and with public demands and needs. In 1962 the private insuring organizations—Blue Cross, Blue Shield, insurance companies and independent plans paid out $4.2 billion to help cover the costs of hospital care. Total health insurance benefits for this period, including loss of income protection, totaled $7.1 billion.

Newer types of coverage; extended benefit, major medical, etc., have been developed and are being improved, to provide an increasing degree of protection. The pattern of year to year growth in all types of coverage will continue as our voluntary prepayment organizations broaden the range and scope of benefits to accommodate the diversity of needs and resources of families.

W. VINSON PIERCE, M.D.

TRIPLE SULFA THERAPY is safe at levels of pH 5.5 or lower where the possibility of crystalluria would be greatest.

TRI-AZO-MUL
TRI-AZO-TAB

TRI-AZO-MUL

Each 100 cc contains:

Sulfadiazine (Microcrystalline)	3.381 gm.
Sulfamerazine (Microcrystalline)	3.381 gm.
Sulfamethazine (Microcrystalline)	3.381 gm.

In a palatable, stable emulsion pleasantly flavored with True Raspberry Flavor. Each average teaspoonful (80 min.) represents .5 gm. (7.7 grs.) of three combined sulfa drugs in suspension. Supplied in pint bottles only.

CONTRAINDICATIONS: Sulfonamides are potent drugs, and may cause toxic reactions. Sulfonamides, therefore, should be given only under constant supervision of a Physician.

TRI-AZO-TAB

Each tablet represents:

Sulfadiazine	0.166 gm. (2.57 gr.)
Sulfamerazine	0.166 gm. (2.57 gr.)
Sulfamethazine	0.166 gm. (2.57 gr.)

Available in White or Pink colored tablets in bottles of 100, 500 or 1,000.

TRI-AZO-MUL (citrated) offers the same formula as TRI-AZO-MUL (plain) with sodium citrate (17.5 gm.).

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do more than 250 mg.

of other tetracyclines?

Because it has up to 3½ times the *in vitro* antibacterial activity[1]...combined with lower rate of decay in serum, slower renal clearance...a favorable depot effect, resulting from protein binding...all providing rapid, higher and sustained *in vivo* activity with as much as 2 days' extra activity.

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE HCl

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. *Side Effects* typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. *Capsules*, 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d. 1. Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.: Demethylchlortetracycline and Tetracycline Compared. Relative *in vitro* Activity and Comparative Serum Concentrations During 7 Days of Continuous Therapy. *Amer. J. Med. Sci.* 243:296 (Mar.) 1962.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

7185-3

Helps speed recovery even in severe muscle injuries

Whether your muscle-injury patient is a professional athlete or just a weekend golfer, you can expect rapid results with 'Soma' (carisoprodol).

This unique drug breaks up both muscle spasm and pain at the same time. Onset of action takes only 30 minutes, and your patient will usually begin to feel better within hours.

As Conant demonstrated in a study of 106 patients with musculoskeletal injuries, 88% of the patients treated with 'Soma' (carisoprodol) achieved good to excellent results. *(Clinical Medicine*, March, 1962.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely. For severe athletic strains or everyday sprains, you can rely on 'Soma' (carisoprodol) to help speed recovery with notable safety.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D.

The muscle relaxant with
an independent pain-relieving action

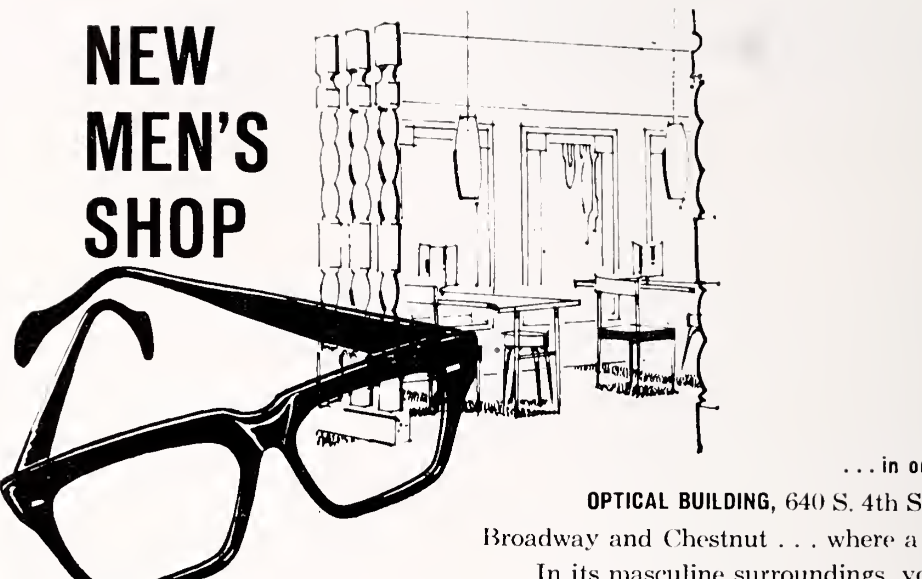
Wallace Laboratories, Cranbury, New Jersey

blood, milk and Maalox® (magnesium-aluminum hydroxide gel)

Practically standard treatment, now, for bleeding ulcer. Why is Maalox included? Antacid therapy *must* continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good; it's effective and will not cause constipation—three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)

RORER

WILLIAM H. RORER, INC., FORT WASHINGTON, PA.



... in our **NEW SOUTHERN OPTICAL BUILDING,** 640 S. 4th St., between Broadway and Chestnut . . . where a man is king. In its masculine surroundings, you'll experience the same comfort while being fitted for glasses as you do when being fitted for clothes.

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Anesthesiology Residency
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Cleveland Clinic — Available Now

Fully approved program available to graduates of approved medical schools who have completed an approved internship. Offers wide practical experience with all agents and methods including endotracheal intubation, spinal, regional and block anesthesia. Anesthesia for all surgical specialties including chest and open heart procedures, vascular surgery, and neurosurgery.

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PHYSICIANS or PSYCHIATRISTS for 2600 bed modern State Hospital near Medical Center (Dallas). Physicians, $11,000 to $12,000. Psychiatrists, $13,500 to $16,000. Texas license or eligibility for reciprocity from another state required. Contact Superintendent, Terrell State Hospital, Terrell, Texas.

"They keep saying I'm sloppy!"

Nicozol® helps you restore your geriatric patients' interest in themselves

NICOZOL therapy can help you brighten the outlook of your aging patients who tend towards (1) untidiness, (2) irritability, (3) incompatibility, (4) lack of interest, and (5) loss of memory or alertness.

The NICOZOL formula helps improve mental acuity, increase the supply and use of oxygen in the brain, improve peripheral circulation—without excitation, depression, or other untoward effects.

NICOZOL can help you keep your aging patients actively alert and at ease with themselves, their families, and others.

Supplied: NICOZOL tablets (and capsules) in bottles of 100 and 1000. NICOZOL elixir in pints and gallons.

Precautions: May produce overstimulation in high doses. Discontinue if muscular twitchings or clonic convulsions occur. The flush produced in sensitive individuals is transient and harmless.

Average Dose: 1 to 2 tablets (or capsules) 3 times a day. 1 teaspoonful elixir 3 times a day.

Formula: Each tablet or capsule contains:
Pentylenetetrazol............100 mg.
Nicotinic Acid.................50 mg.
Each teaspoonful (5 cc.) elixir contains:
Pentylenetetrazol............200 mg.
Nicotinic Acid...............100 mg.
(as the sodium salt)
Alcohol..........................5%

HART | Division of A. J. Parker Co. LABORATORIES Bryn Mawr, Pa., Winston-Salem, N.C.

NICOZOL®

PUBLIC HEALTH PAGE

Chest X-Ray Services*

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

FOR many years, the Tuberculosis Control Program has been offering free chest x-rays to the general public as a case-finding measure. Until January 1962, the mobile x-ray units visited each county annually and took only 70mm photofluorographic or "miniature" films. Since then, additional units have been provided and counties are now visited monthly or at least once every three months. In addition to the PFX screening film, standard 14x17 chest x-rays are also done on request.

Since the overall cost of a 14x17 film is approximately $2.00 as compared to 20c for a miniature film, it is important that the 14x17 film should not be requested if a PFX film will do as well.

It should be stressed that the PFX film is a highly reliable means of *detecting* the presence of any pulmonary lesion. It is not, however, satisfactory for making a diagnosis of the nature of the lesion. In short, it is a screening technique, not a diagnostic one, but as a means of finding pulmonary disease, it is very dependable.

It follows, therefore, that the PFX flim is a perfectly satisfactory x-ray for the routine examination of apparently healthy persons, such as food-handlers or contacts who have no indication of pulmonary disease. The standard 14x17 film, then, should be reserved for those who are either known to have pulmonary disease, or those in whom there is a strong suspicion of disease.

This article was prepared by M. Stuart Lauder, M.D., C.M. Director, Tuberculosis Control Program Kentucky State Department of Health, 257 East Main Street, Frankfort, Kentucky.

To clarify the distinction, the following groups should have 14x17 film:

(1) Known cases of tuberculosis.
(2) Persons who have had an "abnormal" PFX flim.
(3) Suspects—persons who have symptoms suggestive of pulmonary disease. (other than the common cold)
(4) Persons who would normally have a PFX film but who for various reasons would be difficult to recall in case of a dubious PFX film—the very aged and infirm, those living in inaccessible areas, and the uncooperative.

The following should normally have a PFX film:

(1) Contacts and other positive reactors.
(2) Occupational groups — teachers, food-handlers, etc.
(3) Routine films for insurance, as part of a complete physical examination, and so forth.
(4) People who "want an x-ray."
(5) Surveys

It is our policy not to x-ray anyone under eighteen years of age, unless a positive tuberculin reactor or referred by a physician. Pregnant women are also x-rayed only on referral.

In addition to the sevices of our mobile units, the Tuberculosis Hospitals are not conducting regular extension diagnostic clinics in about forty counties. These provide specialist consultation and are primarily for the supervision of known cases of tuberculosis and for suspects referred by the family physician. Appointments should be made in advance through your county health department.

Important news in cardiac therapy

Two new clinical reports document successful long-term treatment of ischemic heart disease with Persantin®, brand of dipyridamole

See next 3 pages

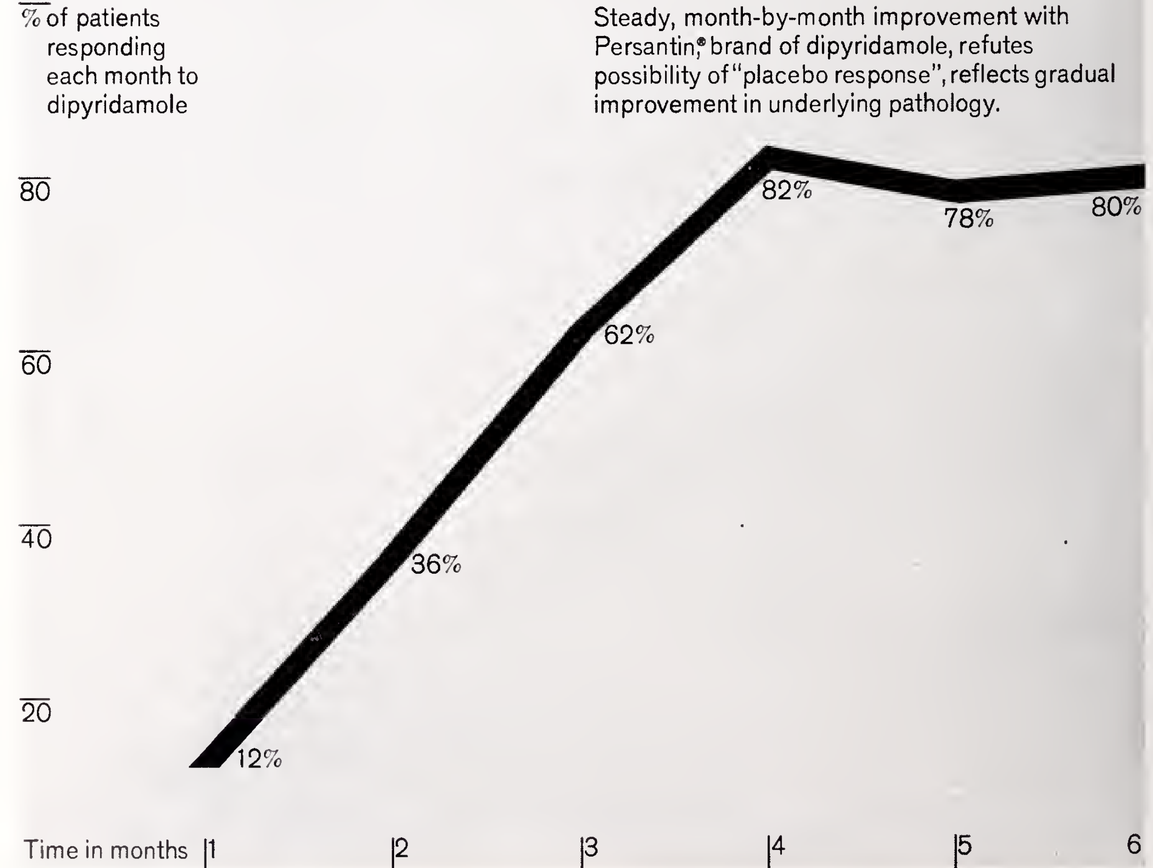
Study 1.
Griep, A.H.: Long-term Therapy of Ischemic Heart Disease With Oral Dipyridamole: A Report of Fifty Cases. Angiology 14:484, 1963.

Persantin,® brand of dipyridamole, 25 mg. t.i.d. or q.i.d., was administered continuously for 6 months to 50 patients with well authenticated ischemic heart disease with angina pectoris and ECG abnormalities. Results were evaluated on a monthly basis.

Persantin® brand of dipyridamole

"...long-term oral therapy with dipyridamole was of benefit in 80 per cent of the patients...

"relief [of angina] came slowly and was usually maximal after three to six months of continuous treatment"



Study 2.
Wirecki, M.: Dipyridamole (Persantin®): Evaluation of Long-Term Therapy in Angina Pectoris. Current Therapeutic Research 5:472, 1963.

In 40 ambulatory patients with myocardial ischemia, angina pectoris, and abnormal ECG findings, Persantin® brand of dipyridamole, 25 mg. t.i.d., was administered continuously for 3 months.

Geigy

After 3 months, 32 of 40 patients showed:

"...reduction or abolition of acute anginal attacks...

"complete or almost complete disappearance of ECG abnormalities...

"marked increase" in walking distance without anginal symptoms

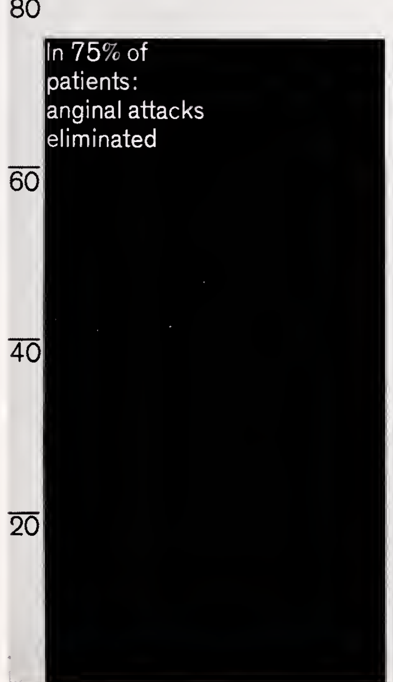
% of patients

80

60

40

20



Persantin® brand of dipyridamole

How long-term therapy provides clinical benefits reported on previous pages

1. By increasing energy yield of the hypoxic myocardial cell, by direct action upon the sarcosomes (heart mitochondria).[1-5]

2. By improving collateral coronary circulation. Prolonged oral administration of dipyridamole to animals with experimentally induced stenosis of a major coronary artery resulted in superior development of collateral coronary anastomoses and longer survival compared with controls.[6-9]

When given for prolonged periods and in adequate dosage, dipyridamole improves the coronary flow deficit of the ischemic myocardium while supporting cardiac metabolism during the period of repair. Clinically, this is manifested as steady improvement – anginal attacks diminish in frequency and intensity, as do other manifestations of insufficiency (dyspnea, fatigue, and, in many instances, abnormal electrocardiographic findings).

Availability:
Tablets of 25 mg., bottles of 100 and 1000.
Under license from Boehringer Ingelheim G.m.b.H.

Prescribing summary: Persantin,® brand of dipyridamole, is indicated in coronary and myocardial insufficiency, in a dosage of 2 to 6 tablets daily in divided doses before meals for several weeks. Side effects (headache, dizziness, nausea, flushing, weakness, syncope, mild gastrointestinal distress) are minimal and transient. The drug is not recommended in the acute phase of myocardial infarction, and should be used cautiously in hypotension.

References: 1.Kunz,W.;Schmid,W.,and Siess,M.: Arzneimittel-Forsch.12:1098,1962. 2.Siess,M.: Arzneimittel-Forsch.12:683,1962. 3.Laudahn,G.: Experientia 17:415,1961. 4.Lamprecht,W.: 27th Congress of the German Society for Circulation Research,Bad Nauheim,1961. 5.Hockerts,T.,and Bögelmann,G.: Arzneimittel-Forsch.9:47,1959. 6.Vineberg,A.M.,et al.: Canad.M.A.J.87:336,1962. 7.Chari,S.R.,et al.: Presented at the International Congress of Chest Physicians,New Delhi,1963. 8.Neuhaus,G.,et al.: Presented at the Fourth World Congress of Cardiology,Mexico City,1962. 9.Asada, S.,et al.: Japanese Circ.J.26:849,1962.

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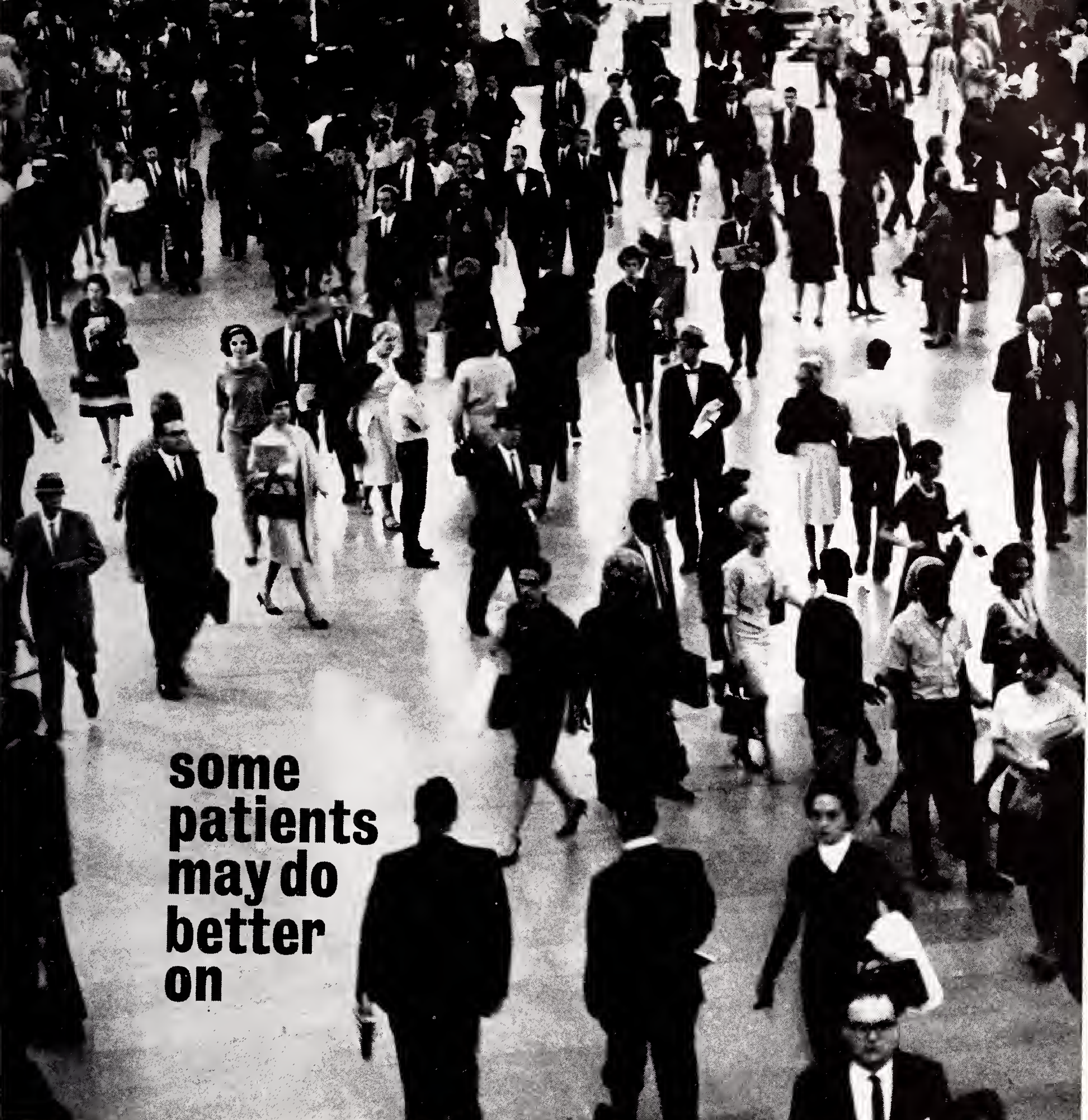


ACHROCIDIN®

TETRACYCLINE HCl-ANTIHISTAMINE-ANALGESIC COMPOUND

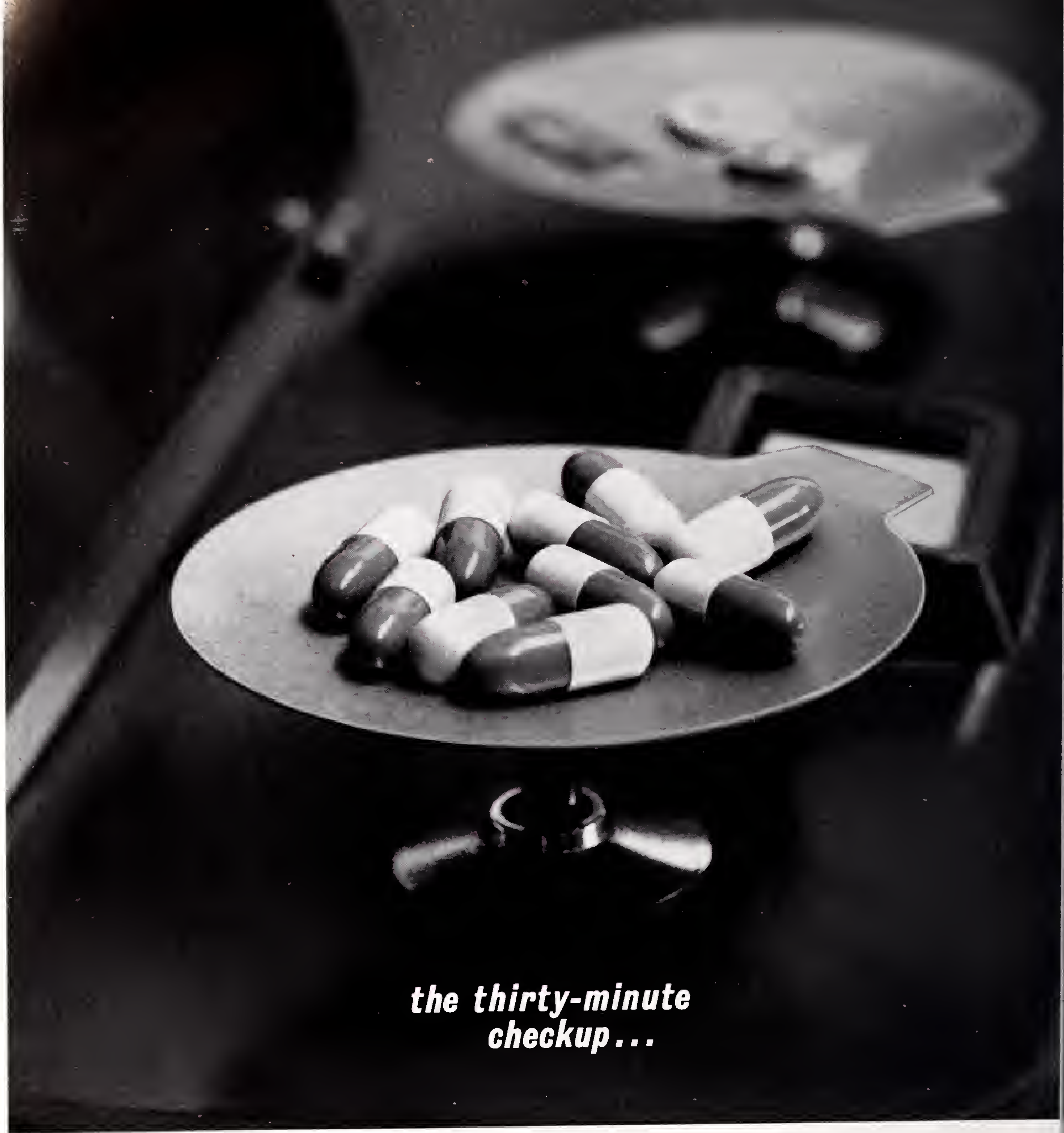
Each Tablet contains:

ACHROMYCIN® Tetracycline HCl	125 mg.
Acetophenetidin (Phenacetin)	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Effective in controlling tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects are drowsiness, slight gastric distress, overgrowth of nonsusceptible organisms, tooth discoloration. The last named may occur only if the drug is given during tooth formation (late pregnancy, the neonatal period, early childhood). Average Adult Dosage: 2 Tablets four times daily.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York *Lederle*

7142-3



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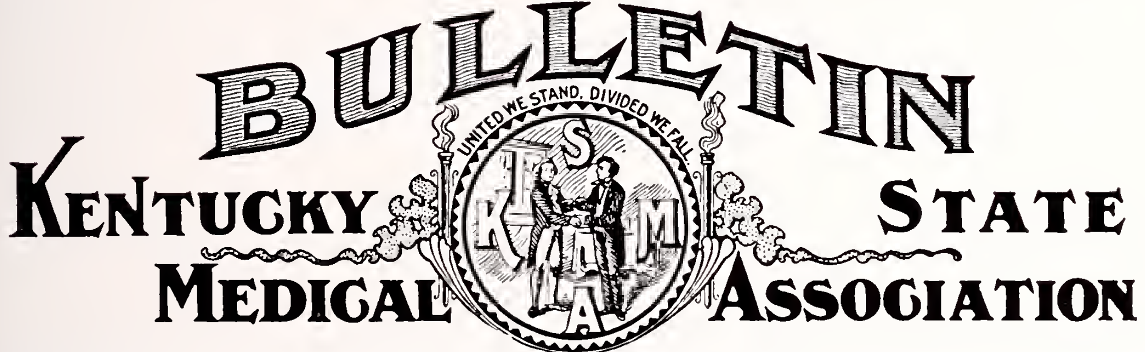
VOLUME 61 | NOVEMBER, 1963 | No. 11

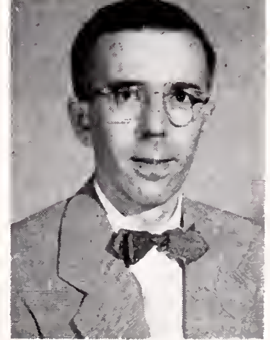
Sixtieth Anniversary Issue*



Vol. 1. LOUISVILLE, KY., JUNE, 1903. No. 1.

Introduction

THE first issue of the Journal of the Kentucky State Medical Association was published in Louisville in June 1903, under the title of "Kentucky State Medical Association Bulletin". This publication was made possible through the efforts of the Publication Committee, comprised of James B. Bullitt (Louisville), Secretary (KSMA), Chairman (Ex-Officio); Arthur T. McCormack (Bowling Green); J. E. Wells (Cynthiana); and, by the authorization of the House of Delegates of the Kentucky State Medical Association. Doctor Bullitt was the editor, and the success of this new venture was largely the result of his imagination and untiring efforts. From 1851 through 1902, the Transactions of the Kentucky State Medical Association had been published annually in book form.


Doctor Conner

The new bulletin kept the Kentucky physicians informed of the activities of the various county societies. This, in turn, promoted formation of other societies in counties and communities in which the practitioners had not, as yet, associated for the exchange of ideas and the discussion of medical problems. In the first issue of the publication, it was stated that "The Bulletin will concern itself with anything and everything which has interest for, and relation to, the medical practitioner of the State of Kentucky".[1]

I sincerely believe that the Journal has continued to carry on this original concept in both

** The 60th Anniversary issue was prepared and edited by Eugene H. Conner, M.D., Professor and Chairman of the department of Anesthesiology at the University of Louisville School of Medicine—Editor*

[1] *Editorial, KSMA Bulletin 1, p. 28 (June) 1903.*

spirit and practice for, as Guest Editor of this 60th Anniversary Issue, I have had the interesting task of carefully looking over nearly all issues.

Our Editor, Doctor Sam Overstreet, gave me one basic ground rule in the selection of papers for reprinting—papers contributed by members still living should not be chosen. Had this restriction not been placed, difficulty in making these selections would have been far greater. The original type, format, illustrations and advertisements that follow are presented in an effort to recapture the spirit of the original publication.

It is a distinct honor to have been invited to edit this issue, and I should like to express my appreciation to you, my fellow members of the Kentucky State Medical Association, for your confidence and encouragement. Many of my colleagues have cheerfully come to my assistance, and I should like to thank, especially, Doctors James C. Drye, Emmet Field Horine, Arthur H. Keeney, Thomas N. MacKrell and Donald M. Thomas.

It is hoped that the papers chosen for this 60th Anniversary Issue of the Journal of the Kentucky State Medical Association may reflect the progress made by the medical profession in Kentucky and throughout the United States, toward a healthier, happier community of peoples.

Eugene H. Conner, M.D.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

James Harry Hendren, M.D.
(1873-1944)

DOCTOR HENDREN was born 27 November 1873 at Speedwell, Kentucky, where his father operated a general store. He received his early schooling at Speedwell and Richmond. After graduating from the University of Kentucky where he majored in chemistry, he taught school in Salem, Oregon.

He attended the Hospital College of Medicine in Louisville, from which he graduated in 1902. Practicing first in Rockcastle County, Doctor Hendren later removed to Pineville. During most of his professional career he practiced in mining camps in Bell County. His greatest interests were the study of Pellagra, a disease which ravaged his patients during his early years in practice, and the application of ultra-violet light in medical treatment.

Doctor Hendren enjoyed fishing and camping. Despite many demands upon his time, he was active in the Boy Scouts, the Kiwanis Club and the Christian Church.

The paper reprinted from Ky. Med J. *11,* 367-383, (1 May) 1913 exemplifies Doctor Hendren's interest in Pellagra and also demonstrates his familiarity with epidemiologic methods for study. Although Pellagra was soon demonstrated to be a non-contagious disease (contrary to the popular belief of that time), this article documents the extent of the disorder and the problems it created in the rural areas of this State early in our 20th Century.

PERSONAL OBSERVATIONS OF PELLAGRA IN EASTERN KENTUCKY.* **

By J. H. HENDREN, Cary.

I feel deeply the very high honor that has been conferred upon me in being asked to address this splendid assembly; and feel more keenly still my utter inability to present to you something worthy of your esteemed consideration.

Why this committee on programme should have gone far back in the dim recesses of the mountains, to the most remote corner of the State, and dragged therefrom a quiet, obscure, and to you unknown country practitioner of medicine, to address you upon the most vital, the most important, and the most obscure question before the medical world to-day; is to me a mystery: but since in their wisdom they have seen fit to do so, I shall endeavor in feeble way to present to you the salient points of this subject as best I can.

The subject which has been assigned to me is a discussion of that wide-spread malady, pellagra, and while we know but little of its symptoms, less of its cause, and still less of its cure: it is still none the less the most important topic of the present medical generation.

Far be it from my purpose in this article to present to you a rehash of the literature on pellagra, but so much has been written, so much has been said, and so little really known about this important matter that is is impossible for any man to treat this subject without some reference to the work of others.

The history of pellagra in the old world is a matter of centuries: but in the new, at least in the United States, it was unknown prior to 1864. Since that time sporadic cases have been reported in the east and south, by various observers. Since 1908 the reported cases of pellagra in the United States has increased by leaps and bounds, until now, conservative investigators estimate 25,000 cases east of the Rocky Mountains alone.

Writers have written, students have studied, and thinkers thought about this plague, for two centuries, but the cause of pellagra is as much a mystery to-day as when Cassal first mentioned it in 1735. It was he who first originated the idea of some causal relation between corn and pellagra. The medical fraternity of that time, having found a new disease, sought some recently acting cause. Indian corn or Zea maize had been recently introduced into Europe as a staple article of food and for certain reasons attention was drawn to it as a causal factor of the trouble.

All the writers and thinkers upon pellagra may be divided into two great classes or schools. First the "Zeists" or those who believe that Indian corn is in some way responsible for the trouble; and second the "Anti-Zeist" who deny any such relation whatever. Unfortunately neither school has been able to concentrate its forces upon one single line of thought. We have had divisions and sub-

*Read before the Kentucky State Medical Association, Louisville, Tuesday, October 29, 1912.

**Reprinted from *Ky. Med. Jour.* No. 9, Vol. XI, May 1, 1913, pp. 367-383.

divisions until now we have nearly as many causes advocated as we have investigators. It is not the purpose of this article to laud any particular theory to the skies, to ride any special hobby to the exclusion of all the others; but to present all the facts in as clear and as concise manner as possible, and let you be the judge.

First the "sub-nutritious" theory; the idea that corn as a food stuff is wanting in some of the essential elements that go to make a well-balanced ration, and that people who use it to any great extent as an article of diet, undergo a process of slow starvation. But with our modern chemical and physiological laboratories, we find that sound, well dried, mature corn is one of the most available as well as the most nutritious of all the foods offered to the human race. In both fats and carbohydrates it ranks above barley, buck-wheat, rice and wheat; while in fuel value per foot pound it leads all the cerials on the list. As our knowledge of corn and its products has increased, the adherents of this theory have decreased until now it has but few if any advocates on either side of the Atlantic.

Second, the "photo-dynamic" theory, brought forward by Raubitschek in 1902, that corn contained some substance which circulating in the blood stream, was decomposed by sunlight into other toxic substance or substances, which acting upon the central nervous system, produced those symptoms we call pellagra. So far this theory has met with little favor.

Third, the "toxico-chemical" theory, that by the action of certain bacteria or molds, corn may undergo certain changes in the process of spoiling with the formation of one or more toxic substances, which when absorbed into the human system produce a chain of symptoms we call pellagra. This is the great spoiled corn theory in a nutshell, "In pellagra we are dealing with an intoxication produced by the poisons in spoiled corn, through the action of certain micro-organisms, in themselves harmless to man." This idea was first advocated by Lombroso, who has been its most ardent exponent, and embraces by far the larger part of the Zeistic school at the present time. This is the view accepted by the Italian government, which has spent thousands of dollars in prophylactic measures, and makes it the official cause of pellagra at least so far as Italy is concerned.

Lombroso has been the high priest of the ziestic school; his arguments have been weighty and powerful. He was a hard worker and a deep thinker, and a trenchant writer, and since his death the material he left behind has proven a bulwark of the adherents of the maize theory; and all that may be said or written must partake in some nature at least of his argument. Investigating chemically Lombroso found three substances in spoiled corn upon which he laid great stress:

First, a red oil, with bitter taste and musty odor.

Second, "pellegrocein" a toxic alkaloid, resembling strychnine.

Third, a resinous substance.

Experimenting with these substances on man and the lower animals, he has been able to produce symptoms resembling pellagra, but it is the concensus of opinion of more recent investigators that these symptoms are not comparable to pellagra in man.

The "toxic-infective" theory. This is similar to the toxico-chemical theory, except that the poisons are generated within the intestinal tract by the action of certain bacteria, especially the colon bacillus. It is true that the colon bacillus is found in all cases of pellagra, but it is also true that it is found in the alimentary tract of many other individuals of the human race, both sick and well, as well as some of the lower animals. As the yeast fungus breaks up the edible sugar into intoxicating alcohol and water, so may certain other bacteria produce other substances in the alimentary tract, equally as poisonous or more so.

The "parasitic" theory. Bacteriology is always a fertile field, and the bacteriology of pellagra has been one of the most interesting chapters in both the history and etiology of the disease. Many bacteria, each claiming to be specific in their nature, have been reported by various investigators, and each in turn has been discredited by more recent and careful investigation. In 1906 Tizzoni isolated the "strepto-bacillus pellagrae" from the blood and stools of pellagrins and also from spoiled corn, which he claims to be the specific cause of the trouble. Bacterium maydis, aspergillus flavedcens and fumigatus, blue mold and many others, have been brought forward, but the work of their respective investigators lacks confirmation.

In opposition to the zeistic theory, there arose a school of observers, especially in France, who began to report cases of pellagra where it was claimed that no corn had ever been ingested, and who denied "in toto" any causal relation between corn and pellagra. This has been called the "anti-zeistic" school. Unfortunately the anti-zeists are as widely separated in their ideas as to the true etiology of the disease, as the zeists.

Among the first theories of the anti-zeists was that pellagra was not a disease *per se* but a "symptom complex" of some underlying malady such as cancer, syphilis, alcoholism, or malaria. In the light of our present knowledge all investigators agree that pellagra is a disease, and the "symptom complex" theory is without foundation.

An Italian investigator has recently brought

forth the argument that pellagra is due to a water-bourne nematode worm, which floats in the blood channel. His observations lack confirmation.

Dr. Mizell, of Georgia, brings forth the theory that pellagra is due to the ingestion of certain "semi-drying edible oils" especially cottonseed oil. Dr. Lavinder dismisses the subject with this well directed fling: "By interweaving certain known chemical reactions with certain unsupported personal opinions and then applying unwarranted interferences as to the metabolism of the human body; it has been made to appear that some of the end oxidation products may cause the disease."

Of all the anti-zeistic theories, that one which has possibly been given the most consideration, is the protozoan theory. This was first promulgated by Dr. Sambon in 1905 and later much amplified by him in 1910. It was he who brought forth the various objections to the corn theory as a cause of pellagra, which may be summarized as follows:

1st. Although the zeist presented this theory nearly 200 years ago, there is no agreement among themselves as to just what substance, or in just what way corn acts to produce the disease.

2nd. A poison will not cause recurring seasonable attacks increasing in severity long after the patient has ceased to take it in his food.

3. Corn fails to explain why pellagra occurs among the rural population and not in the cities.

4th. Pellagra occurs in persons who do not eat corn, or eat it but rarely; especially in infants of tender months who have never taken of food but mother's milk. The attacks recur long after the patient ceases a corn diet.

5th. Corn fails to explain why the disease is so prevalent in warm countries and so scattering in colder climes.

6th. The numerous prophylactic measures such as inspecting, drying, and maturing of corn has had no effect in lessening the prevalence and severity of the disease.

7th. Corn fails to explain why the disease is more prevalent among females; more often associated with streams; why generally in the low lands and not on the hills.

8th. Corn fails to explain why certain endemic centers of the disease remain the same for centuries. Sambon, Lavinder, and other observers have been frequently impressed with the statements of practitioners in pellagrinous sections that all their cases came from certain localities.

Sambon further elucidates the idea that pellagra was not contagious, but spread through the agency of some "intermediate host" possibly an insect, as malarial and yellow fevers, sleeping sickness, and others of this type. His theory was based upon the following facts:

1st. Pellagra occurs in tropical and sub-tropical countries, where infective diseases, especially diseases caused by protozoans and parasitic worms, are prevalent.

2nd. Pellagra is a rural disease.

3rd. Children six months old develop the disease.

4th. Pellagra bears a distinct relation to the seasons in all countries where it exists.

5th. Infectious diseases are epidemic in character, as cholera; or endemic as malaria. Pellagra is both epidemic and endemic, but never pandemic.

6th. Pellagra like all other infectious diseases shows a marked increase in the lymphocytes.

7th. Pellagra, syphilis, malaria, and sleeping sickness are all alike benefitted by arsenic.

8th. Diarrhoea is a characteristic of infectious diseases.

9th. The topographical distribution of pellagra does not coincide either with the distribution of maize culture, or with that of maize consumption.

10th. The zeistic contention that pellagra did not occur in Europe until after the introduction of maize is a mooted question.

Sambon further believes that the disease is transmitted by a minute blood sucking fly of the genus Simulidae, and bases his convictions upon certain facts he claims to have established, a detailed description of which is not necessary at this time.

In discussing the topic before us, it is not my intention to go into the broad subject as a whole, but to confine myself to one particular locality: to give as nearly a true history of the cases that have occurred in this locality as I possibly can, together with their relation to the surroundings and to each other.

I herewith present to you a map of Bell county. It is in the extreme southeastern corner of the State, and its principal industry is coal mining. It has a population of about 30,000 people, 50% of them live in the mining camps of the various coal companies, 35% in the towns of Middlesboro and Pineville, and the remaining 15% are scattered over the county, engaged in agricultural pursuits on small farms.

It was here that pellagra first made its appearance in Kentucky, and it was from here that the ripple started that sent the whole medical fraternity as well as the laity of the State into one grand ground swell of discussion pro and con.

On July 7th, 1911, the Bell County Medical Society met at Cary, and a clinic of seven cases of pellagra was presented at that meeting. The matter was discussed rather extensively by the local press, and one month later, August 9th, 1911, a "Pellagra Conference" was held in Corbin, at which nearly one hundred physicians were present, and in a

triangle of Bell, Whitley and Knox counties over one hundred cases were reported.

The section of the country where this dread malady came so suddenly into prominence is one of great scenic beauty. The tranquil Cumberland winds its devious way to the westward and lofty mountains pierce their towering craigs mid the thunders sullen roar. On every hand the rivulet and the rill bounding from their rocky beds meet the sunbeam in the spray, and scatter their diamonds on the passer-by. A hundred little towns and villages dotted here and there besprinkling the verded slopes like jewels to an emerald isle;—presenting in all a scenic grandeur excelled by no other section of the State, and equalled by but few in the nation.

I desire to call your attention to the rectangle marked off near the center of the map. This is about one and one-half miles wide by three miles long, embracing about three thousand acres. It contains 500 houses and about 4,000 population.

We have here a map of the same rectangle mapped upon a more extensive and accurate scale. Within this rectangle we have been able to get a rather complete history of 80 cases of pellagra from 1910 to the present time. Not only this, but we have been able in most instances to trace the migrations of families and their relations to other families. The drinking water, diet, domestic conditions, and such conditions as might possibly have some bearing upon the disease, have all been studied and noted carefully. It is not my purpose to give a full detailed history of all the cases within this map at the present time: such would be too much repetition and tax the patience of any audience. Not all the cases mentioned are now within the limits of the above named boundary. Some have moved away and others died. In all there has been ten deaths within this boundary, and four others who have lived here, but died elsewhere. However, I desire to submit this record of these cases to the proper board of this society. If after a perusal of the same, they deem it worthy of publication in pamphlet form they have my permission to do so; if not they can consign it to the waste basket.

In studying the disease, some peculiar facts present themselves: First, a majority of the cases are among the natives of this section, not in persons who have migrated into the section, but in persons who have lived here all their lives. Cases No. 18, 19, 20, 22, 23, 25, 28, 31, 33, 35, 37, and 38 are typically local. Second, there were no known cases of pellagra, nor any disease similar to it, prior to 1906.

From the standpoint of etiology, the zeists have much in their favor. Before the advent of the railroad, the natives of this section were a quiet, peaceable farmer folk, untrammeled by the outside world. They raised their corn in the little valleys, cared for it at home and had it ground into meal at the local water mills which were common here. In 1905 the railroad was built, and mining camps began to spring up like mushrooms in a night. In 1906 the population of his valley grew from 200 to more than 2,000 people. Valleys not used by the railroads were used by the mining camps. Farming was no longer profitable and the natives deserted the fields for work in the mines. Instead of using home grown supplies they were dependent upon the company stores for "shipped-in stuff." The old water mill was silent and the mill stones still. What relation corn bears to pellagra I do not know, but the fact stands forth boldly that no cases were known here till after the advent of "brought-on" food stuffs. Ninety-five per cent of the inhabitants are dependent entirely upon the mining industry for a livelihood, and possibly ninety per cent. of all the food products come through the commissaries, or in other words is "brought-on". The daily life of the miner is in no sense to be compared to the poor of Egypt and Italy. All the families are supplied with good warm houses, boxed and ceiled, and all have good stoves upon which to cook, with plenty of wood and coal to cook with. That the miner as a rule lives well, is shown by the fact that very few accumualte any savings. They prefer to eat and dress it out. Fresh meat and vegetables with milk and butter they have in season, and the table of the mining class is always better spread than the poorer class of the cities. Many have little gardens around their houses, and the mining companies, as a rule, encourage such thrift. Corn products are abundantly sold in the commissaries. Corn meal, hominy, breakfast foods, corn syrup, and such things form a large part of their daily sales.

The majority of the male population are lovers of "corn juice" and many of them imbibe freely, but the female population, as a rule, are free from this vice. Both male and female, old and young, almost without exception are heavy users of tobacco. They dip snuff, smoke or chew, sometimes all three. Both male and female population are remarkably free from drug habits; only two or three "dope fiends" in the entire section. The women as a rule are lazy and shiftless; bad cooks and worse housekeepers. Cooking in old-fashioned Dutch ovens with fire above and beneath, is a lost art in this section. Corn bread is baked in thick pones generally on top of the stove, the middle of the bread often being uncooked. Flour bread, when used, is made with baking powder. Fried meals are generally preferred to the boiled ones: the meal that can be prepared with the least trouble, regardless of expense.

The climate is all that can be desired. We have neither the hot sultry nights of summer nor the driving winds of winter, so common to the blue-grass and the cities. There are but few nights through the summer months that blankets do not feel comfortable, and the high mountains ward off the driving wintry blasts. The average elevation of the homes is 1,000 feet above sea level, while the mountains are from 500 to 800 feet higher.

As a rule, the water supply is obtained from bored wells, 75 to 125 feet deep. This depth insures a pure, clear, cold, sparkling beverage, rich in iron and well charged with carbonic acid gas. Unfortunately all the families do not use this water, but some prefer to use water from surface springs which is not safe.

The sanitary condition of the camps is bad. But few of the closets had vaults until the present year. These have been of the open type, free of access to hogs, chickens and flies alike. Scarcely any of the houses are screened, and the pesky flies find access to all homes alike. Houses for the most part are not underpinned, and hogs, calves, dogs, geese and chickens find a common bed beneath. Flies, fleas, bedbugs, and cock-roaches are the common inhabitants of all homes. Hookworm, round worm, and tape worm abound, and of 500 specimens sent to the State Laboratory for examination 65% show hookworm infection, and 85% show intestinal parasites of some kind.

The protozoan theory of Sambon calls for some intermediate host in whose body the protozoan passes one or more stages of its existence. Studying the subject from this aspect presents some difficult problems. Blood-sucking insects in this locality are not numerous, mosquitoes are not nearly so common as in the central and northern part of the State, and do not attract very much attention. Both Professor Garman, of Lexington, and myself have collected specimens of anopheles punctipennis (the malarial mosquito), and stegomya faciata (the yellow fever mosquito). Since becoming interested in this subject it has been my custom to set a lighted lamp on the front porch of my residence, collect such insects as come about it, and send them to Prof. Garman for identification. The larvae of the simulidae have been found in considerable quantities in the streams in various parts of this locality. These localities I have marked with an X on the map. Of course the presence of the larvae necessarily implies the presence of the adult, but neither Prof. Garman nor myself have ever been able to catch or trap this elusive insect. Repeated attempts to hatch them in the Station at Lexington proved unavailing, and a rather elaborate aquarium fixed up at my home likewise proved a failure. The most venustum although other species may be identified later. This larvae is rather thick bodied, more later. This lavae is rather thick bodied, more slender in the middle, becoming thickened at posterior extremity. Though varying in size and length, they average about 1-8 of an inch in length, of a dark-brown color, and attach themselves to the underside of rocks in shallow, swift running streams. One peculiarity noticed was that they seem to prefer the fords of the streams where wagons and horses stirred the water often. Another peculiarity was the marked, uneven distribution even in the same stream. They would be found abundantly in one place, a quarter of a mile away abundantly in the second place, but in the intervening water they were found very sparingly, if at all. This peculiarity has not been satisfactorily explained. Again but few, if any, larvae would be found in that part of a stream running through a mining camp, although, found above and below the camp. This is possibly due to the mine waters, sewerage or more probably to the waste oils from the machinery.

Unfortunately the season of 1912 has not been favorable for the study of water-bourne insects. Heavy rains throughout the season, have kept the streams in a swollen condition, and much damp weather during July and August prevented the flying of many species. It is hoped that another season will prove more favorable for this work.

Another insect worthy of consideration in this connection is the punkies or no-see-ems. These are quite common in this locality, and sometimes after sunset appear in great numbers. They bite both man and beast, and I have collected many on my saddle horse. After lighting they get down to business at once, and in a very short time are gorged with blood.

I would consider that I had not done full justice to the subject before me if I did not mention hookworm in this connection. In the various cases of pellagra reported in this paper, nearly every one has shown the presence of hookworm. The section of the country just discussed, shows not only the largest per cent. of pellagra but also the largest percent of hookworm infection; 65% of the total population by actual examination being infected. May it not be possible that there is some direct relation between hookworm and pellagra? May it not be possible that the hookworm at some period of its existence excretes some toxico-chemical substance, which in turn produces those symptoms we call pellagra? Is it not a well known fact that pellagra first presents itself as a toxic poison on the gastro-intestinal mucosa and later upon the skin? What sympathetic relation is more closely allied in the human frame than that of the skin and gastro-intestinal mucosa? Does not a sin-

gle dose of quinine often produce a redness of the skin equal to scarlet fever? Can not this account for the fact that the disease is non-contagious? Can not this account for the non-transmissibility of the disease in utero? Would this not explain why pellagra is not found in cities? Has not Italy and Egypt alike been the home of pellagra and hookworm for centuries? Could not this account for the absence of a specific protozoan on the blood? Would this not answer at once Sambon's charge, that the decrease of pellagra in Italy is due, not so much to the improved methods of handling of corn as to the improved sanitation? Can it be merely a coincidence that nearly every case of pellagra shows hookworm infection? One thing that I have ntoiced is that "In the height of the diarrhoea of pellagra, no hookworm eggs are found, while in the quiescent stage of the disease they may be found plentiful in the same patient." Why this is I do not know. Perhaps in this stage the worms lay no eggs, or perhaps in the excessive watery diarrhoea they are too scattering to be found. Could the hookworm be the intermediate host of the protozoan of pellagra? Has it not been proven over and over again that every case of pellagra treated for hookworm shows some improvement? These are some of the things that I have not threshed out in my own mind, but I hand them out to you for your consideration.

Another thing that I desire to call attention to is that the mines in this section have never been worked by foreign labor, as have many of the Pennsylvania and Virginia mines. Greek, Hungarian, Polish and Italian labor is here unknown. It is hardly possible that some Italian pellagrin has infected the "intermediate host" and left it to infect the remaining inhabitants.

In the study of pellagra, two things very forcibly present themselves: First, the great predominance of female patients, and second, "house infection." While some few cases seem to have developed spontaneously, without any history of previous exposure or contamination; (as cases 1, 16, 17, 18, 28, 29, 32, 36, and 43), the majority of them can be traced to an exposure to the disease by living in a house previously occupied by a pellagrin or by close association with one.

Case No. 28 moved to the McFarland house on August 16, 1910, and moved away November 17, 1910. Another family moved in the next day and cases 4 and 5 developed in this family in July, 1911.

Case No. 16 lived in Slusher cottage No. 1, from September, 1908, to December 1, 1908. Another family moved in and case 34 in this family developed pellegra in July, 1911. Case 49 who lived in cottage No. 2, next door, and often visited case 16, developed pellagra in 1910.

Case 18 developed pellagra in 1910, in an isolated farm house. Case 19 nursed her mother, case 18, until her death, and developed the disease in May 1911. In May, 1911, case 20, a son, moved into the house in which his mother contracted the disease, and lived there until October, 1911. This man developed pellagra in March, 1912.

Case No. 1 developed pellagra while living in house No. 14, Cary camp, in June, 1910. Cases 2 and 3 (sons of case 1) developed the disease in 1911. Another family moved into house 14, and a case has developed in that family in this year, 1912. A grandson of case 1 (case not recorded) now has the disease.

Case 44 boarded during the month of July 1911, in a family with one pellagrin, and developed the disease in April, 1912. Second eruption of case 44 occurred in September, 1912.

Case 46 moved into a house at Wilton in 1911, immediately after a pellagrin died therein, and developed the disease in the spring of 1912. Case 43 developed pellagra while living in house "B" (Baker cottage) possibly in 1907 or 1908. Case 31 moved in and developed the disease in 1909 or 1910. Case 31 is also a sister-in-law to case 65 and spent much time with her.

From the practice of Dr. B. E. Gianinni, of Straight Creek, Dr. J. S. Lock, of Barboursville, and others I have been able to collect about 20 cases of "house infection" not mentioned here.

For my part I am not a believer in the "corn theory" of pellagra. In the study of the hundred or more cases that have come under my personal observation I see nothing to indicate that corn is a causal factor in the trouble, and much to indicate that it is not. It is true that 90% of the corn products used in this territory has been shipped in from other sections, but why should so few be attacked by the disease when so many use the same diet? When case 4 developed pellagra, she heard and read so much of the corn theory that she has abstained from corn meal entirely ever since. However, the disease has steadily progressed. Case 32 has never used corn meal to any extent. It is a well known fact that in the flouring mills of this country, many of the helpers form the habit of eating raw meal fresh from the stones; yet so far as I know no cases of pellagra have been reported among such helpers.

While working on this subject in the summer of 1912, it occurred to me that perhaps the "cimex lectularius" or common bed bug might be the long sought-for "intermediate host." While this obnoxious insect does not as yet answer all the requirements of the many angled situation: there are certain angles into which its characteristics fit remarkably well. After working along this line for some time, I accidentally discovered that my

Cases 4 and 5.

friend and co-worker, Dr. B. E. Gianinni, of Straight Creek, held to the same theory. We joined our forces and did some experimenting and research work, but for the want of a microscope and other laboratory equipment our work was necessarily crude and our observations far from convincing. We hope to begin earlier next year, and may be able to present something worthy of your consideration at a later date.

I believe that the true theory to this vexed problem will be found in a modification of the protozoan theary of Sambon, but I am frank to say that I think Sambon acted hastily in incriminating the simuliidae as the "intermediate host." In the literature that I have been able to gather on this subject there has been but little said either pro or con in regard to the simuliidae. The distribution of pellagra and the distribution of the sand fly are certainly not coincident, in this country at least.

After a careful study of the literature on the subject, and a careful observation of the cases that have come under my personal observation, I have reached the following conclusions, which (though they may be wrong) I desire to present to you.

First: The use of Indian corn and its products as a food, have nothing to do with the cause of pellagra, nor with the continuation of its symptoms, even after it has been caused by some other agency.

Second: That there is most probably an "intermediate host", but the evidence at the present time is not sufficient to incriminate the simulidae of Sambon.

Third: That the "stage of incubation" is much longer than that of any other known disease, probably six to twelve months.

Fourth: That no physician is justified in diagnosing a case as pellagra until the eruptive stage has appeared.

Fifth: That pellagra is not contagious "in utero," nor can it be transmitted from mother to child through the medium of mother's milk.

Sixth: A large per cent. of the cases appear associated with or in the wake of some other disease, as measles, smallpox, but more especially child-birth.

Seventh: That the disease is produced by a micro-organism, either a protozoan, or an organism similar to the organism of syphilis; perhaps a spirochoeta or a spirillium.

Eighth: That the germs of the disease are located principally in the brain and spinal cord, and that they do not circulate in the blood stream except possibly under certain conditions.

Ninth: That the cure for pellagra will be found in the use of arsenical compounds, possibly one not yet brought out, and most probably one used intravenously.

Tenth: That until we know more of the cause of pellagra, segregation and prophylactic measures are useless.

Eleventh: That the eruption of pellagra is not due to the germs of the disease per se, but to the toxins generated by them.

Twelfth: That a large number of the cases seem to develop an immunity to the disease, each attack growing less and less severe, until the disease disappears.

Thirteenth: All proof of its transmissibility from person to person seems negative, although there is strong evidence that it is a house infection.

One of the greatest drawbacks in the study and treatment of the disease in this section, is poverty. Miners as a class have never learned how to "lay by a little for a rainy day." What's in the pay envelope on Saturday night is spent on Sunday and they meet the world face to face, even up on Monday morning, ready for another cut, shuffle and deal. Sickness in the home is at all times a burden, and when it strikes the bread winner or the housewife, it is hard indeed to make both ends meet. Mine physicians are as a rule poor men. Their average salary is $125.00 per month. They are called upon not only to visit and prescribe for the patient, but to furnish the drugs as well. This with the high cost of living, and the requirements of his social position, leave him but a narrow margin for experimentation or to buy costly equipment.

Let the cause of pellagra be what it may, it certainly does exist in this locality: and possibly

here as nowhere else in the United States: and here I believe it should be studied.

Pellagra is here to stay, until its true cause is found and it yields its sceptre to some conquerer, I hope American born. May we of Kentucky not be found wanting, for to him who solves this knotty problem comes the plaudits of mankind, and an honor nobly won.

Case No. 1.—Case No. 14 of Dr. R. M. Grimm.

Mrs. John F., female, white, married, age 44, mother of 8 children; six people in family, two other mild cases in the family. First developed symptoms in 1910. The eruption appeared in blackberry time, which in this section is June. It has been made to appear in the literature that this case developed in the Roark cottage, but on more careful investigation, I find that this case developed in house No. 14, in the Cary Camp, a slide of which is herewith shown.

This case was seen by Dr. R. M. Grimm in August, 1911, and by Prof. Garman in September, 1911. (See Bulletin No. 159, page 8). A photograph occurs in State Board Bulletin, Vol. 1, No. 9, and has been copied extensively over the United States.

This case is interesting in many ways. First the disease presents but little intermission in its symptoms. The eruption occurs regularly about every two months, and the mental symptoms have been marked throughout the disease. Being a blonde of very fair skin, the eruption shows exceedingly well. This is the case referred to by Prof. Garman in Bulletin 159, pages 8 and 9.

This woman has all her life been of a weak, nervous temperament; always complaining about some ache or pain, a confirmed patent medicine fiend; chewed tobacco and dipped snuff. During the last year of her life she became a convert of the faith cure religion and took very little medicine. It is impossible to trace just where she contracted the disease. The family moved often, sometimes five or six times in a single year, often because she became dissatisfied with a place and wanted to change. From November, 1911, to June 1912, she lived beyond the reach of my personal observation, but in June, 1912, she moved back to Cary. Her condition at this time showed great change. Weak and emaciated much diarrhoea, and sore mouth, eruption prominent, loss of appetite, increased salivation, mind wandering at all times. From the middle of June to her death she was confined to her bed. The disease progressed rapidly: extreme emaciation, greatly increased salivation, marked involvement of the vagino-rectal areas, greatly increased reflexes, complete loss of appetite, mind completely incapable of any concentration of thought or ideas. She imagined, for instance, that the hips had become unjointed from the body, and wanted a surgical operation to replace them. Patient died of exhaustion, August 20th, 1912, at 7 p. m.

Case No. 4.—Case No. 20 of Dr. R. M. Grimm.

Mrs. Malinda McF., female, white, widow, age 53, mother of 8 children, married at 21, widow at 51. Lived a large part of her life in and around Whitley county, Kentucky. Moved into the McFarland house in Fox Ridge camp on November 18th, 1910, and lived there until September 9th, 1912. In June, 1911, she had a sore mouth and diarrhoea that was possibly the beginning symptoms of pellagra. In July following she had the first eruption, which was rather extensive: very red and firey and extended nearly to the elbows. Seen by Dr. McCormack and others in August, 1911. The eruption disappeared in the fall and winter of 1911, but many symptoms remained. Was very constipated, complained of a burning in the feet and legs all winter: would sleep with feet from under cover in the very coldest weather. Complains of much burning in the stomach and bowels, as if they were raw. Shows hookworm infection but declines to be treated for it. Has spots and sprangles before the eyes, knee-jerk greatly exaggerated. Eleven in the family, all equally exposed to the infection, one other mild case in the family. Complains of great muscular weakness, sits about most of the time. All symptoms returned in the early spring of 1912, the eruption remaining most all summer. Some loss of weight. A dear lover of corn bread and has eaten it all her life. Has used very little, if any, since the disease appeared. Died January 1, 1913.

Case No. 5.—Case No. 21 of Dr. R. M. Grimm.

Edna W., female, white, child, 4 years old, grandchild of case 4 and lives with her. Developed eruption about the same time grandmother did, though mild. In the fall of 1911, this child had a severe attack of cerebrospinal meningitis and life was despaired of for many days. Recovery complete, and through the winter of 1911 she seemed normal. I watched her closely and no symptoms reappeared until September, 1912, when the telltale eruption on the hands and feet began to show. She has had no diarrhoea or sore mouth this year. The case seems to be a light one.

Case No. 9.— Case No. 6 of Dr. R. M. Grimm.

Mrs. D. B. R., female, white, married, age 38, mother of 8 children. Lived on Dorton Branch during 1908 and 1909. Moved to House No.—, in Cary camp, in December, 1909. Had several attacks of very sore mouth in the year 1910 which could not be accounted for. A child was born June 13th, 1910, but can remember no eruption appearing during this year. Moved back to the Roark cottage on November 4th, 1910, and de-

Baker Cottage (House "B")—Case 43 Contracted the Disease Here. Case 31 Also Lived Here but it is Uncertain Where she Contracted the Disease.

veloped eruption in the latter part of May, 1911. Very sore mouth but no diarrhoea. Hands began to burn and later got red and peeled off in dry branny scales. Also appeared on the neck, but not on the feet. Baby nursed mother until July, 1912 and has no appreciable signs of the disease. Cases 10, 11, 12, 13, all in the same family and the same house. Return of the eruption in the early spring of 1912, also in July of the same year. Patient has felt much better in 1912 than in the year 1911. Never knew of any cases of the disease until she had it. Lived within 50 feet of case 1 during December, 1909, and January, 1910. Symptoms seem to be decreasing in severity. Lives within 50 yards of a creek in which Prof. Garman found similium larvae in abundance.

Case No. 10.—Gertie R., male, white, age 14 years, son of case 9.

First developed eruption in June and July, 1911, on both hands and feet; Sore mouth but no diarrhoea. Returned in April and July, 1912, but not very marked in either case. No sore mouth or diarrhoea in 1912. Case mild and decreasing in severity.

Case No. 11.—Case No. 7 of Dr. R. M. Grimm.

Ashley R., male, white, age 8, son of case 9. Developed eruption first in July, 1911, while living in the Roark cottage. Severe sore mouth and diarrhoea marked the attack. Eruption on hands and feet and neck. Some return later in the fall. Return of the trouble in May, 1912. No return in July but some in September, 1912. The attacks are becoming much lighter, except the attack of September, 1912, which is the most severe of the year.

Case No. 16.—Case No. 11 of Dr. R. M. Grimm.

Mrs. Wm. R., female, white, age 26, three children, one dead. Moved to Big Hill camps in May, 1907, and lived there till March, 1908. The first eruptive symptoms appeared from March 1st to March 15th, 1908. Moved to Chenoa in May, 1908, and lived there till the following September. During the summer of 1908, she was sick a great deal, in bed part of the time. Had much diarrhoea during the summer, and was treated by physicians for "catarrh of the bowels." In September, 1908, she moved to Slusher cottage No. 1, and lived there till December 2, when she moved to Cary. During the summer of 1909 this patient was very bad, being in bed most of the entire summer. She was seen by some four or five physicians, who were all of the opinion that she was suffering from tubercular peritonitis, and so treated the case. During the winter of 1909-10, she became much improved and seemed to be practically well. During the spring and summer of 1910 the symptoms returned very slightly, if at all. In September, 1910, she was delivered of a healthy child, which nursed the mother's breast. Nothing was particularly noticeable during the winter of 1910, but in the spring of 1911 the symptoms returned with all their vigor. The full chain of symptoms

returned early in the season. Much emaciation and prostration. In bed most all summer. Nursed infant throughout the summer, contrary to advice. Seen by Dr. J. N. McCormack in August, 1911, who said she would be dead in two weeks." Dr. Grimm also considered her case "early fatal."

In September, 1911, patient moved from Cary to Chenoa. During the winter and fall of 1911 she improved somewhat but was never well. During the summer of 1912 she has been in better health than for some time. She is able to do her own housework, even to washing and ironing. During the summer of 1912 she has had several returns of the eruption in a mild form, together with the sore mouth and diarrhoea. The eruption extends above the elbows on the arms, and is typical on the neck. Last year it appeared on the face but has not appeared there this year. This woman has gained very much in weight. In September, 1911, she weighed 107 lbs; in September, 1912, she weighed 149 lbs.; in October, 1912, 165 lbs.

This case is interesting for several reasons: First it is the oldest *authentic* case in this section. Second., it is much better every even year, and much worse every odd year. Third, a child born two years after the first eruption and nursed the mother's breast one year, has shown no appearance of the disease.

Case No. 17.—Case No. 13 of Dr. R. M. Grimm.

Mrs. Sam G., female, white, married, age 38, mother of 6 children. The eruption in this case was first noticed while living at Elys in March, 1909, but very little attention was paid to it. Don't know whether it returned in the fall of that year or not. Moved to Cary in January, 1910. Delivered of a child on February 12, 1910, which died in about ten days of broncho-pneumonia. Moved to Elys in March, 1910, and immediately developed a case of small-pox which was rather severe. Moved to Stony Fork and lived there during the summer of 1910. Was treated by Dr. Schultz for the eruption, but did not recognize its nature. Had several attacks of diarrhoea during this period. Moved to Cary in March, 1911, and lived there till November, 1911. I saw this case for the first time in May, 1911, but did not definitely make up my mind as to the true nature of the disease until about the first of June. At this time she was very weak, unable to walk without help, mind foggy, eruption, diarrhoea, sore mouth, and mental symptoms all prominent. This was one of the cases presented at the clinic on July 7th, 1911, already referred to.

About July 1st, 1911, this patient was placed on a treatment of creosote, oil wintergreen, and glycerine equal parts, and for some reason a very marked improvement of all symptoms was noticed. The patient was able in a short time to do her own housework, something she had not done for many months. The eruption faded away and did not return during the season. Patient moved out of my reach during the winter of 1911, but in February, 1912, moved back to be treated by me. Eruption returned in March, 1912, in a mild form; very little other symptoms except the mind was foggy. The accompanying photograph was taken March 19, 1912. Patient continued to grow worse until May 1st, 1912, when she passed into convulsions, with many tonic and clonic spasms; these continued with less and less severity, complete loss of mind, incontinence of urine and feces until May 19th, when she died of exhaustion.

This case is interesting because it was the first case of pellagra in the State that was publicly diagnosed as such, so far as I know. It is also interesting in that it showed marked improvement under a certain line of treatment which later refused to do any good. The patient was also in a state of spasms for nineteen days before her death, which is very unusual in these cases.

Case 18.—Mrs. Margaret L., female, white, widow, age 55. Taken sick in February or March, 1910. Had a bad diarrhoea, eruption on hands soon after. Not seen by any physician. Mind began to fail in June of same year. Had been living in the same house for three years. Moved to Arjay camps in the following winter. I saw patient soon after. Mind completely gone; singing, praying, hallucinations, very weak and exhausted; not able to walk across the room. Confined to bed from about February 1st, 1911. Grew rapidly worse. Saw patient five or six times. No eruption that I noticed. Incontinence of urine and feces. Died of exhaustion March 28th, 1911. Diagnosis was not made in this case until about one year after death.

Case No. 19.—Henry L., male, white, married, age about 25, day laborer in mines, son of case 18. Noticed eruption in early spring of 1912. No diarrhoea or sore mouth. In May, 1911, moved to same house mother lived in when she contracted the disease, and lived there until October, 1911. In October, 1911, moved near to case 24, and associated with him all winter. Patient complains a great deal of stomach trouble. No return of the symptoms during the summer of 1912 up to this time. Patient has gained weight and says he is cured.

Case No. 20.— Case No. 16 of Dr. R. M. Grimm.

Dora L., female, white, age 18, single, daughter of case 18 and associated with her all through her life. Waited on her during her last illness. Eruption appeared about May, 1911. Seen by Dr. Grimm in August. Was then on back of her hands

and forearms; typical collarette; very much run down in health. Has been no return of the symptoms that I know of. Have not seen the case for some months.

Case No. 21.—Case No.—of Dr. R. M. Grimm.

Dock J., male, white, married, coal miner, age about 50. Patient developed a very sore mouth and obstinate diarrhoea in July, 1911, while working in the mines. Was diagnosed as a case of "pellagra sine pellagra" at the time. Seen later by Dr. Grimm, who concurred in the diagnosis. About the middle of August the patient became so weak that he was unable to continue work longer on the mines and in a few days the eruption became prominent. Patient continued to lapse between better and worse until late in the fall, when he began to improve and seemed normal throughout the winter. Moved away in the winter and I have not seen the case since. I understand that he has some trouble this summer.

An interesting phase of this case was that the eruption did not appear until the patient was compelled to quit the mines, and then it appeared very promptly. This man worked every day in the mines and was exposed to very few, if any, of the daylight influences if pellagra. No other cases in his family of eight at home.

Case No. 22.—Case of Dr. F. D. Haston, Arjay, Ky.

Mahala S., female, white, married, age 26, mother of 4 children, one dead. Two years ago a scaly eruption occurred on the back of both hands, accompanied by diarrhoea; otherwise general health fair. About February, 1st, 1912, mouth became sore and ulcerated; some diarrhoea. About March 1st, 1912, eruption appeared on both hands, scaly; burning sensation increased on exposure to the sun. Complains of burning sensation in the stomach. Has continued about the same throughout the summer. Diet largely corn bread. Seems to be a mild case. This case is complicated with syphilis and the results of "606" will be watched with interest.

Case No. 23.—Mrs. Lizzie B., female, white, married, age 29, mother of 5 children, one dead. Weak, nervous temperament, always on the sick list. Developed mild eruption in March, 1912. Has lived in the same house for five years. Had no sore mouth or diarrhoea. Symptoms have not returned at this time; may develop next year. Not a positive case.

Case No. 24—Case of Dr. F. D. Haston, Arjay, Ky.

Joe K., male, white, married, age 32, day laborer on farm. Has been in comparatively good health all his life until about March 1st, 1912, when he developed a diarrhoea, profuse at times, associated with much pain, and a little later a very sore mouth, and scarlet red eruption on back of both hands. About the middle of May a typical collarette developed on the back of neck. Loss of energy and weight. Appetite bad at times. More fond of corn bread than any other bread-stuff and eats much of it. A near neighbor of case 19, and associated with him a good deal. Moved to Clay county in the summer and further trace of the case lost.

Case No. 25.—Case of Dr. F. D. Haston, Arjay, Ky.

Mrs. Lizzie L., white, female, married, seven children, three living. Family history good, always been in fairly good health. Gives history of having sore mouth for seven or eight years at intervals, but very much worse in the early spring of 1912. About March 1st, 1912, a scarlet red eruption developed on the backs of both hands, with a burning sensation, worse in the sunshine. About May 15th, developed a diarrhoea, with burning in the stomach, but no abdominal pain. Very fond of corn bread; won't eat any other bread when she has corn meal. Never lived in a mining camp. Case 22 lives 1-4 mile away on same creek. Has lived in the same house two years, and in 100 yards of same place for seven years. Very quiet disposition, rarely visits, even the neighbors.

Case No. 26.—Case of Dr. F. D. Haston, Arjay, Ky.

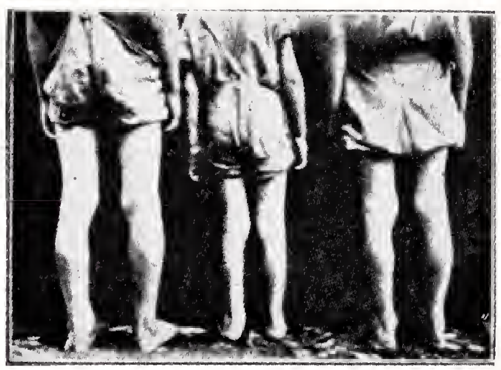
Mrs. Henry Q., female, white, married, age 39, mother of 8 children. First noticed eruption in March, 1912, never had any special sore mouth or diarrhoea. Some bloody discharges in July, 1912; mental symptoms very pronounced, a marked pellagraphobia. Has lived in the same house for one year before the eruption appeared, and never saw a case of pellagra to her knowledge. Lives in a closely settled mining camp, but no other cases very close about. No case of pellagra had ever lived in the same house before. No other cases in the family.

Case No. 27.—Mary W., female, colored, age 63, mother of 12 children. Developed a case of eruption on the hands twenty years ago, immediately after the birth of a child; called by attending physicians "erysipelas." This trouble got well with no return of symptoms until 1911. First noticed eruption in the spring of 1911 in "gardening time" (April). Had a bad diarrhoea and sore mouth at the same time. I saw this case several times in June and July, 1911. The height of the eruption had passed but the dry chocolate brown scaly condition was typical, as was also the diarrhoea and sore mouth. A well-marked Cassall collar was present. The most noticeable symptom was the mental condition. When a stranger first entered the room she seemed perfectly rational,

and could answer questions truthfully, but after a while her mind became foggy and answers were very incoherent. The family first noticed that her mind was wrong in the summer of 1910. She began by singing, praying and teaching Scripture. Mind continued to get worse until sent to the Eastern Kentucky Asylum in September, 1911. A letter in query to her history while in the asylum received the following reply:

Lexington, Ky., July 31, 1912.—Dr. J. Harry Hendren, Cary, Ky.—Dear Sir: Your letter of recent date received. While Mary W., was here she was in very bad condition physically and went home in a very weakened condition. She might have had some symptoms of pellagra while here, however her case was not a decided one. Yours very truly, C. A. Nevitt, M. D., Supt.

Her mind evidently cleared up to some extent, as she was dismissed from the institution in March, 1912.



Cases 57, 58 and 59.—Typical Eruption on Back of Legs.

In April intense gastro-intestinal symptoms reappeared. By May 1st this was so intense that the patient could neither eat nor swallow water. The mental condition was fairly clear to the last and no eruption appeared, perhaps because patient was not in the sun. She died of exhaustion on May 9th, 1912. I regret that I have no photograph to offer.

This case presents two interesting features: First, this patient may have had the disease twenty years ago, and second, there may be some cases of pellagra in the various asylums of the country in which the diagnosis of pellagra is yet unmade.

Case No. 28.—Same as case 127 of Dr. R. M Grimm.

Eva Lee L., female, colored, age 17, single. First developed symptoms of pellagra while living at Straight Creek; has been living in the same house for four or five years. This occurred in the early spring of 1910. Attended a supper in April, and developed a sore mouth the next day; thought she was poisoned by eating something. This was followed by a mild diarrhoea, then the eruption.

Patient moved from Straight Creek into the McFarland house in Fox Ridge camp on August 16th, 1910, and lived there until November 17th, 1910. Moved to another house in the same camp and died June, 1911.

This patient was of a very quiet disposition: rarely visited even among the neighbors. Spent most of the time at home; a great reader, but shunned company. Never out of the State of Kentucky. Five members of the family, no other cases in the family, or among the colored of the immediate vicinity. Had nothing to do with case 27.

Patient was always able to be about the house until the latter part of May, 1911, when she took her bed. All the symptoms progressed rapidly; the hands, elbows, shoulders, knees and feet, were covered with thick heavy scales that were prone to bleed on the slightest provocation. The sore mouth and salivation was terrific. She would lie on the side of her face and the saliva would drain down an oilcloth into a cup prepared for it. She seemed to think that her whole trouble was due to "piles" and that was her whole complaint. Repeated examination showed one little hemorrhoid, about the size of a split pea, yet the patient thought that the whole chain of symptoms would be relieved if that were removed. Patient was baptized by immersion in a creek two days before her death. It did not seem to injure her in any way.

Case No. 32.—Case No. 17 of Dr. R. M. Grimm.

Henry H., white, male, single, age 37, coal miner, first developed pellagra about 6 years ago while living in Whitley county. The attack was severe at that time. During the seasons of 1907, 1908, 1909, and 1910, there was no return of the trouble. Did his usual work during these years. In the spring of 1911 the trouble recurred with unusual vigor, beginning about the first of May. Remained more or less prominent during the whole season. Patient was presented to the Pellagra Conference clinic at the Corbin Convention on August 9th, 1911, and attracted a good deal of comment on account of the prominence of the symptoms. During the season of 1912, all the symptoms have been slight, not enough to keep the patient from his usual work in the mines. Patient has moved about considerably since the disease first appeared, living in West Virginia part of the time. This patient does not like corn bread, and never uses it if he can get any other bread, but is a dear lover of corn syrup, and partakes of it heartily: He does not drink.

Case No. 34.—Herbert C., white, male, age 7

years. Family moved into Slusher house No. 1, on December 3rd 1908, immediately after case 16 moved out, and lived there until November, 1909. Moved to Straight Creek, and developed an eruption in the spring of 1911. Eruption appeared on the feet only. No sore mouth or diarrhoea at this time. Second appearance in the early spring of 1912, on feet only. Third appearance in July, 1912, on both feet and hands. Has never had any sore mouth or diarrhoea, about the time of the eruption, but has had a looseness of his bowels all his life. Whole family prefer corn-bread to any kind of bread stuff, and use much of it at all times. Used water from a shallow well, which tasted very bad at times. Mrs. S., case 49, lived next door during the entire time that this case lived in the Slusher cottage. Family now live in Cary camp, house No. 15.

Case No. 36.—Case of Drs. Nuckols and Giananni, Straight Creek, Ky.

Lindsay P., male, white, married, coal miner, age 55. This man moved to Straight Creek and lived there from 1904 to 1910. In September, 1910, he moved to Breastwork Hill, a suburb of Pineville, and lived there two months. Moved to Dorton Branch December 10, 1910, and lived there until September 1911, when he moved back to Straight Creek. The family history in this case is decidedly negative. Most of his people live to a ripe old age.

The first symptoms of pellagra developed in the spring of 1911 possibly May or June. Was thought to be a sunburn due to hoeing in the garden. No sore mouth or diarrhoea or other noticeable symptoms at this time. Family noticed that he was nervous and irritable, something unusual for him. In August, 1911, was injured on back of head by accident in mines; in bed ten days. From this time on, patient complained of dizziness, roaring in head and other unpleasant symptoms. Said head was too big for body; hard to balance himself; would step backward two or three times before he could steady himself. Worked in the mines regularly till March, 1912. Complained of feeling drunk all the time. Memory failed rapidly and could not attend to any business. Would repeat things to his family often. Did not like to talk; said his jaws were tired; very nervous, any unusual noise upset him; an organ in the home remained unopened for many weeks before his death.

Slight eruption appeared in May, 1912. Feet and legs began to swell one month before death. Had no knowledge of ever having been with a pellagrin, or ever having seen one. So far as traceable no pellagrin ever lived in the houses occupied by him. This patient had no marked diarrhoea except in the last month of his illness.

Died July 26th, 1912, apparently of exhaustion.

Case No. 37.—Mrs. Virgie H., female, white, married, age 18, mother of two children, one and possibly both afflicted with the disease. Has been living in Cary for two years. First noticed eruption in April, 1912. Had a very sore mouth and bad diarrhoea at this time, eruption followed. covering the forearms nearly to the elbow. Moved to Harlan Court House in May, 1912. Eruption appeared again in July, 1912, as did also the sore mouth and diarrhoea. Photographed this case in August, 1912: the eruption had mostly disappeared, but the chocolate brown markings were very plain. Unfortunately the photograph fails to bring out the markings as clearly as desired. Patient has a salty taste in the mouth often, and wants much salt in her food. A neighbor of case 1 and often visited her. Never lived in a house where a pellagrin had lived, to her knowledge.

Case No. 38.—Rena Belle H., age 3, female, white, child of case 37. First noticed eruption in July, 1912, in Harlan Court House. Had a diarrhoea and sore mouth at the same time. When I saw this case in August the height of the eruption had passed, but the markings were very characteristic on the hands and feet as the accompanying photograph will show.

This case had no sign of the trouble in the early part of the spring when her mother was attacked, and in all probability caught the disease from her mother, either directly or indirectly.

Case No. 39.—Case No. 3 of Dr. O. P. Nuckols.

George B., white, male, married, coal miner, age 46. Patient was an old asthmatic case, which had been treated by nearly every physician in Eastern Kentucky. A wanderer from place to place. According to Dr. Nuckols, had a mild eruption on the back of hands in the fall of 1910, which disappeared later. Early in the spring of 1911, he suffered greatly from weakness and vertigo. About the first of June the eruption returned and extended up to the elbows, also about the neck and edges of the hair, soon becoming a dirty brown, dry and scaly. Red tongue, dry parched lips, occasional diarrhoea: power of locomotion much disturbed; would fall about as if drunk; had to use two canes to steady himself. Reflexes irregular, mental condition depressed, never very good. On July 9th, 1911 patient had an attack of asthma with considerable oedema of the lungs, and died next day, July 10th, 1911, of oedema of the lungs.

George Albert Hendon, M.D.
(1871-1941)

DOCTOR Hendon was born and raised in Scott County, Mississippi. He received his M. D. degree from the Louisville Medical College in 1894. Following graduation, he was one of the first interns at the Louisville City Hospital. Beginning in 1895 as an instructor in surgery at the Hospital College of Medicine, he maintained his academic affiliations throughout his lifetime. He became Professor of Surgery in 1903 at the Hospital College of Medicine, and in 1908 continued in this capacity when the school was merged with the University of Louisville School of Medicine. From 1923 until 1935, he was Clinical Professor of Surgery at the University of Louisville.

Doctor Hendon was an able surgeon and an excellent instructor and lecturer. His most absorbing interests were the treatment of intestinal obstruction, the pre- and postoperative care of the patient by use of venoclysis and the treatment of fractures of the hip. Of the more than 100 published papers of Doctor Hendon, the majority are devoted to these three subjects. He was a pioneer in the use of venoclysis for the correction of dehydration and electrolyte deficit, and a vigorous advocate of early operation in the treatment of intestinal obstruction.

The paper reprinted here is one of Doctor Hendon's earlier papers and exemplifies his pioneer efforts to teach the intelligent management of intestinal obstruction.

INTESTINAL OBSTRUCTION.*

By Geo. A. Hendon, Louisville.

The importance of a study of this malady can scarcely be exaggerated. There is no disease, not even cancer, in which an early diagnosis is so important. In obstruction we measure time by hours, in cancer by weeks. Like cancer it is in the beginning purely a local disease and its cure involves the simplest of mechanical principles, with the advancement of time it becomes systemic and its treatment involves the most complex of pathological problems and the prospects of cure fade with most amazing rapidity. As the diagnosis exceeds in importance the etiology it will be primarily considered.

The symptom first to attract attention is abdominal pain referred to the epigastrium. The pain is first characterized by intermitency. It is acute, sharp, lancinating. Later it becomes constant with sharp exacerbations with closer and closer intervals.

The acute periods being synchronous with the peristaltic wave. The next symptom of importance is notably increased borborygmus due to the violence of the effort of the intestine to force the fecal current past interference. Next in order of appearance and importance is emesis, which at time of onset bears a direct ratio to the distance of the interference from the pylorus. Let us, for clinical reasons, divide the subject of diagnosis into three hour intervals because that is about the average time after onset the patient is first seen by a physician, and at the end of the first three hours the prevailing conditions are but slightly modified as compared with initial sympoms. In this first chapter of physical woe pain is the opening paragraph. Next to pain in point of importance as a symptom and order of appearance is excessive borborygmus. Upon practicing auscultation tempetuous sounds are heard in the cavity indicating the struggle of nature in her effort to clear the passage. Vomiting is the third important sign is likely not to apear in the first interval if the obstruction is below the ileocecal valve, or if the patient has an empty stomach at the time of onset or refrains from taking food after his symptoms begin. If vomiting does occur, however, the material will consist, first, of gastric contents, second, of duodenal contents. I would lay special emphasis upon the presence of any food in the stomach at the time of onset or subsequently as an determining factor of vomiting. Senn long ago called attention to this fact. He noted in his experiments on dogs that they invariably refused food and that vomiting among them was rare as compared to the human subject.

The fourth symptom tympany is variable in the first interval and its absence is not significance

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but its presence correlated with the foregoing does much to complete the picture. Percussion is of small service in locating the point of the lesion unless it be an intussusception or a tumor.

The collapsed bowel drops into the pelvis and the distended portion fills the abdominal cavity, hence a tympanitic note is elicited over the entire abdomen if no tumor is present.

The fifth symptom is marked inability to expel flatus. The bowels may move but no flatus if the obstruction is complete. In this connection I wish to offer the advice that if flatus can be expelled strong purgatives are admissable, but should be withheld upon inability of the patient to pass gas. The test is to give a soap suds enema and if in the expulsion of the enema gas escapes a fair and faithful trial with purgatives is permissable before advising operation.

At the end of the second interval, or six hours from the onset, the symptom above described are exaggerated, especially the tympany. The pulse is materially affected, being rapid and feeble. The temperature arises to about 99 degrees or 100 degrees. Respiration begins to be distinctly thoracic. The vomit contains more duodenal content.

At the end of the third interval, or nine hours from onset, exaggeration of preceding symptoms is well marked and the change is noted in the character of vomit as containing a larger amount of succus entericus from the jejenum as evidenced by its dark green color. The stomach at this stage begins to be visibly dilated, the respiration shallow and rapid, and pain is quite constant. If the obstruction is the obturated variety the patient shows but slight degree of muscular exhaustion and is able to sit up or even walk around the room if he is otherwise well. At this time there begins decided reverse peristalsis and the vomited material is larger in quantity, more acrid and begins to have fecal odor. Pain is intense and the pulse shows marked signs of vasomotor disturbance.

After this period is passed, the first twelve hours, there appears the evidence of systemic intoxication. By this time the wall of gut above the obstruction becomes pervious and allows the intestinal flora to flood the peritoneal cavity. The condition of the patient during the next twelve hours is governed by his power to resist the poisoning of the toxins. There is great distension, prostration, cold extremities, cold nose and copious vomiting of intestinal contents with decided fecal odor. Borborygmus is lessened or absent.

Suppression of urine sets in and complete obstipations supervenes. From this time the contest is fierce between the toxines and natural forces and the weight of a feather will turn the tide of battle the wrong way. I shall not enter a description of the succeeding twenty-four hours, as it is familiar to every doctor, and a more harrowing picture could not be imagined. The clinical picture in the early stage is much influenced by the character of the interference, therefore let us look now at the pathology which involves a study of the factors engaged in producing the obstruction. Let us remember there are three currents, the cessation of either or all three may be the elements of obstruction. The fecal, the vascular, the nerve. In the first the symptoms are most insidious. In the second the pain and vomiting are most violent; in the third systemic effects are soonest noticed; when all three exist simultaneously the gravity of the situation is apparent at a glance. The age of the patient is quite a factor in determining the character of obstruction. In children, the variety known as intussusception predominates. In adult life obstruction by band is most frequent, and in old people volvulus and enterolith are oftenest encountered. By the same tokens we are enabled to form some idea of the geography of the lesions. If the subject is a child we may argue that the condition is one of intussusception and the most frequent site is the ileocecal junction. If the subject is in adult life, we argue that the obstruction is most likely produced by constriction of a band and the most frequent band is the remains of the omphalomesenteric duct situated near the umbilicus, next in frequency is a degenerate appendix which serves a band like effect.

If the patient is in advanced life and the onset has been sudden then torsion of the mesentery of the sigmoid is most probable if the onset has been insidious obstruction by enterolith situated somewhere in the lower twelve inches of the ilium is most likely.

If the symptoms occur secondarily to trauma, or recognized intra-abdominal lesion ileus is most probable. Looking now at the subject from the etiologic point of view in a diagnostic sense; first, if the vomiting, tympany and borborygmus is disproportionate to the muscular exhaustion and vasomotor disturbance and vital depression, obstruction of the fecal current alone is the rule.

If there is absence of constipation great distension, little vomiting, severe pain and great prostration, interference with the circulation, alone, as in mesenteric embolus is a warranted presumption.

If there are mucus discharges from the rectum with accompanying symptoms and the presence of a tumor or definite area of dullness intussusception is to be suspected. In strangulation by band and volvulous all three currents are blocked, hence the symptoms present a compound of the symptoms mentioned above. Morbidity, or what, kills the patient? Answer, systemic absorption of

toxins. The absorption takes place from both the mucus and serous surfaces. The poison is generated in two ways, (a) by intestinal flora, (b) by altered glandular secretion. That which is taken in through the serous surface is the bacteria derivative, they enter the peritoneal spaces through the wall of the diseased bowel while the glandular secretion remains within its mucous lining and are absorbed by the mucous surfaces. The succus entericus is altered largely in quantity and essentially in quality, having been converted by the disturbed hormones into a highly pathological fluid with decided lethal properties. These properties are seen in its action upon the skin which it burns and excoriates wherever it touches, but the mucous membranes seem to enjoy the relative immunity so far as macroscopical destruction of tissue is concerned.

It is well to remember that the lethal effects begin to be manifested and exerted long before the vomited material becomes stercoraceous. I mention these factors because I do not believe proper emphasis has heretofore been laid upon their action. In the event of the gut becoming strangulated and, in consequence, gangrenous, the saprophytes add their contribution to the sum total of disaster.

Pathology in Brief. The most important element to consider under this head is the wall of the gut above the point of obstruction. So long as that remains impervious the systemic symptoms are milder and insidious. The moment the integrity of the gut is lost, great vital prostration is apparent; indicating the wonderful superiority of the serous over the mucous surface as a medium of absorption. Consequently, those forms of obstruction that interfere with the circulation in the gut wall are characterized by the more rapid signs of constitutional toxaemia. It is to be remembered, however, that blocking of fecal current by obturation leads to septic thrombosis of the mesenteric branches in the vicinity, and in consequence a segment of bowel wall much greater in extent than that directly passed upon by the obturating force is damaged. Hence the advice never to remove the obturating body through an incision immediately over the place where it is situated.

It is, however, in primary thrombosis of a mesenteric trunk that the greatest degree of gangrene occurs.

TREATMENT.

The most important consideration in this connection is the removal of the bowel contents, thereby relieving pressure from within upon the wall of the gut, also relieving it from the chemical effects of the pathological secretions. Taking away these morbid influences lessens the perviousness of the bowel to bacteria.

Therefore, with the idea of evacuation *dominant* we begin to consider therapy. Keeping in mind that the importance of evacuation applies oral to the point of obstruction. Obviously the most accessible portion of the alimentary canal to reach with that aim in view is the stomach; moreover the stomach is always above the point of obstruction.

Hence, the first step is to withhold food. I do not think, however, this should apply to water, because what water might remain acts as a dilutant. On the contrary, food of any kind furnishes a pabulum for bacterial growth and in the process of its decomposition liberates gases which add to the distress of the patient.

The next step is to empty the stomach by gastric lavage. This should be done also as a preparatory measure to operation; for, under ether the patient may vomit a great volume of acrid fluid some of which enters the bronchi and produces death by strangulation, or later, by septic pneumonia. The next step is to empty the bowel below the stomach and above the site of interference. This, of course, necessitates an abdominal section. With the abdomen open, if we can liberate the obstruction and see the bowel contents pass along with a peristaltic current we have an ideal case, but too often paresis has supervened and the bowel remains as much distended after the obstruction has been released as it did before. In that event the course to pursue is plain. Release the bowel and empty its contents by introduction of a tube through an incision upon its convex border or by multiple incisions closing the same after the bowel is emptied. This point I regard as of the highest importance because I have never seen a recovery where the bowels were returned to the cavity in a state of distension even if the obstruction was removed.

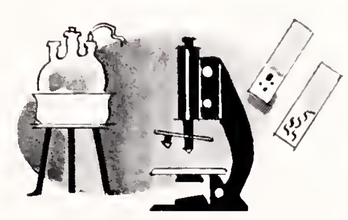
When a more complex affair is encountered our method of procedure should be quite different. In late cases where great vital depression supervenes and the least shock is mortally feared the abdomen should be opened under local anesthesia and the first loop of bowel to appear is brought out of the wound and fastened by sutures then opened for the evacuation of its contents. If, in consequence, the patient improves, the point of obstruction can be dealt with at a subsequent period. In presenting the part of the subject that deals with the management of the point of obstruction, I shall not go into detail, but will refer briefly to the question of resection. This question is easily answered theoretically, but not so, clinically. It is quite simple to advise that if the portion of bowel acted upon by the violence which caused the obstruction has its vitality destroyed it should be resected. But as yet no one has been able

to set an infallible rule to follow in determining the viability of the injured bowel. Of course we know when a gut is black and feels like leather it is dead. By the same token, we know that when a gut is pink and lustrous it is viable. But there is a vast territory for speculation and doubt between these two boundaries. Therefore, if at operation I cannot be convinced either way by the well-known experiment of hot saline application it is better to pack suspected segment outside the cavity where it can be watched and resected later if vitality is not restored. Another procedure of great value in desperate cases is to short-circuit the bowel in its healthy structures above and below the dead bowel, leaving the affected loop outside the wound to be amputated at a later period. This method is a great time saver and shock absorber. In performing the operation as little anesthesia as possible should be used. This can be reduced to the minimum by injecting the line of incision with cocaine or novocain solution.

Another practical point is that the amount of time spent in searching for the obstruction should not be excessive. The patient should not be eviscerated. If failure to find the obstructed point seems inevitable on account of bowel distension this difficulty can be removed by emptying the bowel as above described. It is also worth while remembering that the pelvic cavity contains the collapsed bowel or that below the obstructed point while the distended bowel or that above the obstruction occupies the abdominal cavity proper. I always make a median incision unless a tumor is plainly discernable and search first in the right iliac fossa then beneath the umbilicus for a Meckels diverticulum, then in the sigmoid region. These are the chief localities for obstruction. This paper does not contemplate the various strangulated herniae that produce obstruction or neoplasms or postoperative or traumatic conditions. The post operative treatment consists in the Fowler position, proctoclysis and gastric lavage and all the water the patient can retain. And feeding is instituted on the third day after operation by allowing orange juice and egg albumen. I do not regard enemas or purgatives either before or after operation as part of the treatment. But I do include them before operation as means of assisting the diagnosis. If a response is made to enema or purgatives there is no obstruction.

After operation and release of the bowel movement will occur spontaneously as soon as the gut regains its normal tone.

Until it gains its normal tone no amount of purgatives will avail.



Joseph Addison Stucky, M.D.
(1857-1931)

DOCTOR Stucky was born in Louisville on 6 September 1857, and attended medical school at the Louisville Medical College from which he was graduated in 1878. He studied under James Morrison Bodine, M.D. in Louisville and began the general practice of medicine in Lexington. Doctor Stucky undertook special studies in eye and ear diseases in New York, Philadelphia and in Europe from 1881 until 1884. Beginning in 1885, he limited his practice to the treatment of diseases of the eye, ear, nose and throat. Doctor Stucky was President of the American Academy of Ophthalmology and Otolaryngology in 1903 and in 1907 President of the American Laryngological, Rhinological and Otolaryngological Society. He was made President of the Kentucky State Medical Association in 1921.

Doctor Stucky had an extensive practice in Lexington and became interested in the number of his patients who had trachoma. In the fall of 1910, he made two trips into the mountains of Eastern Kentucky to look for and treat trachoma. His first trip was to Buckhorn, Perry County. Early in April 1911, he held his first clinic in the W. C. T. U. Settlement School at Hindman, Knott County. In May, he held a clinic with Doctor Cowley at Berea. He held a second clinic at Hindman in September 1911 and for the first time, he held clinics at Hazard (Perry County) and Jackson (Breathitt County). Later that September, Doctor Stucky made his first report on trachoma in Kentucky to the American Academy of Ophthalmology and Otolaryngology at their meeting in Indianapolis, and on 8 November 1911, a similar report was made to the Kentucky State Board of Health.

Largely as a result of Doctor Stucky's work, the United States Public Health Service became interested in the problem of trachoma in Kentucky and John McMullen, M. D. was sent in to assist in the design and execution of the program which, by 1936, had completely eradicated this disease from Kentucky.

The following paper of Doctor Stucky's tells of the beginnings of this great program. The elimination of trachoma was an outstanding accomplishment which represented team work by state, federal and lay groups and is a tribute to the indefatigable Joseph Addison Stucky, M.D., and his many colleagues and associates.

Perhaps Doctor Stucky's success may be explained by his favorite verse:

"By mutual confidence and mutual aid,
Great things are done, great discoveries made,
The wise new prudence from the wise acquire,
And one great hero fans another hero's fire."

TRACHOMA IN EASTERN KENTUCKY.* **

By J. A. STUCKY, Lexington.

I think it only fair to the members of this Association to say that I am on the program at this time not by choice but by invitation of the Chairman of the program committee, who besides inviting me, assigned me the topic as published in the program. Some years ago, my curiosity to know from whence came so many severe, many of them hopeless cases, of trachoma from the Mountains led me to take a short trip to Perry County in the Highlands of this State. Then and there I found conditions of the eyes of the natives that were appalling. After that I made semi-annual trips to Hindman in Knott County, where conditions were even much worse than in Perry county. Here I established what is known as my Mountain Clinic, which was conducted in and under the auspices of the W. C. T. U. Settlement School, whose faculty and equipment are doing a remarkable aggressive educational work, combining nearly all the elements of the manual training school work. After the second clinic I was chosen as its

*Read before the Kentucky State Medical Association, Newport, September 22-25, 1914.

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medical director. Until after the fourth semi-annual clinic, each one lasting three or four days, Hindman was 45 miles from the railroad and the long rough trip was made in a day and a half or two days' ride on horse or mule back and in a wagon. On the first trip I was accompanied by two nurses and a guide. Our clothing, instruments and hospital necessities being carried on a pack mule. Finding more work than three of us, with the aid of the nurse and the faculty, at the Settlement School could do, I enlarged my staff and took with me Dr. S. B. Marks, of Lexington, and four nurses. While I looked after eye, ear, nose and throat conditions, Dr. Marks attended to the conditions requiring general medical or surgical treatment. After holding the clinic, on our return to Jackson, of Breathitt county, we stopped at Hazard and saw and operated on cases there.

After the fourth clinic I made a verbal report to the American Academy of Ophthalmology and Oto-laryngology which met at Indianapolis. This report was made with the sincere and earnest desire to get helpful suggestions in treating eye conditions which baffled my hardest efforts to relieve. The following year (after this report) some one called attention to the members of the House of Delegates of the A. M. A., to my report with the result that a resolution was passed asking the U. S. Public Health Service to send one of their experts to co-operate with the Kentucky State Board of Health in the investigation of said report.

Surgeon John McMullen was sent and after visiting five counties in the mountains, his published report (Bulletin No. 101) caused many newspaper and magazine articles to be published and I found myself not only in the spot-light of publicity but with an applause and a reputation that I not only did not seek or desire, but which I feel wholly unworthy of.

I feel that this explanation is not only due you but also is due me. After the active assistance of the Public Health Service was obtained, my ininterest in the people of the mountains and restless desire to help them, by helping to solve the trachoma problem which is their greatest curse and handicap, has led me to points in the mountains, not as yet aided by the Government Health Service, I opened a clinic last April at Oneida in Clay county, under the auspices of the Oneida Baptist School, which has achieved such a phenomenal growth under the guidance of that great man of the mountains, James Burns. Of more than two hundred people examined there I found trachoma in the second or third stage in 16 1-2 per cent of that number. A hospital is being built there now, and an active, aggressive war will be made as at Hindman, Hyden and Jackson, not only against trachoma, but all diseases, insanitary and unhygienic conditions.

Notwithstanding trachoma is one of the oldest known diseases, is infectious and destructive to vision, that it exists in an appalling percentage in the natives of the mountains of the Eastern part of our State, (Kentucky) that our State Board of Health appealed to the United States Bureau of Public Health two years ago, for aid to ameliorate and eradicate the disease, and one of the experts of this Bureau, with three hospitals established, three surgeons and seven trained nurses, constantly in the field fighting the disease, our knowledge of its etiology and treatment "is in a most confused state." The specific cause of trachoma has not been found. Is this a reflection on the Science and Art of Medicine as it is related to ophthalmology, or is it due to the fact that sufficient time and energy has not been given by the bacteriologist and microscopist to the study of the etiology of this most damnable of all diseases of the eye, (especially as it exists in Eastern Kentucky). It is insidious, deceptive, painful, communicable and destructive, and we neither know the specific cause or a remedy or surgical procedure that will restore to function a nominal twenty per cent. of the cases as we find them among the natives (genuine Americans, real Anglo-Saxons) of the mountains in Kentucky, who have the disease in the second or third stage with the usual sequelae of corneal ulceration, pannus, trichiasis and entropion. Scientific research workers have isolated the specific bacilli or cocci that causes tuberculosis, syphilis, cerebro-spinal meningitis, yellow fever, typhoid fever, bubonic plague, diphtheria, pneumonia and many other diseases, no less important and destructive than trachoma, and a rational, scientific treatment has been given, which has practically robbed these diseases of the greater part of their danger and menace to life, but this cannot be said of trachoma. The most humiliating, pathetic and tragic part of this disease, unlike the others just referred to, is it does not destroy life, but if not eradicated or arrested the patient continues to live in his misery, with either impaired or destroyed vision, a burden and menace to his family and the community, and often at last to the State.

It is not my desire or purpose to burden the members of the Kentucky State Medical Society with a lengthy wordy paper on this topic—a resume of the "voluminous bibligraphy on the subject," yet notwithstanding this, "the relations between the older observations and the more recent ones are not clearly defined."

As yet I do not know the etiology of the disease and though I have visited some of the largest and the best clinics in Europe and America, in no

place have I seen such large numbers of cases, such destructive and hopeless conditions in as large a percentage of those afflicted as I have in the mountains of the Eastern part of our own State. To me the treatment and teaching of our best clinicians and the writers of our best text books, indicate "that our knowledge of trachoma lacks exactness."

If any one thinks these statements are exaggerated, or that I have made incorrect diagnosis, they are cordially invited and urgently requested to visit one of the hospitals established by the U. S. Bureau of Public Health for the exclusive treatment of trachoma at Jackson, in Breathitt county, Hindman in Knott county or Hyden in Leslie county.

I have nothing new to add to the paper I read in the Section of Ophthalmology of the American Medical Association in 1913, except since then I have seen 198 new cases of trachoma not reported by me at that meeting, the greater number of these I saw only once or twice, and since I hold only two clinics a year in the mountains, I could do little for them. They cannot come to me nor can I leave my family and my work and go to them. If they ever get relief, it must be carried to them. Just here let me digress long enough to say that these people, are a peculiar, wonderful people, different from the immigrant sweepings of Europe which annually flock to our shores, and which cost us millions of dollars to prevent their bringing trachoma or other communicable destructive diseases to our people. These people are not only genuine Americans but they are Kentuckians, and though the majority of them are on the border line of poverty, they are worth more than their votes; and they have few and short term schools, no roads and meager agricultural facilities, they are our people, and have never had from us and our State Government "a fair chance and a square deal." If they had some of the counties wherein most of the disease of trachoma had been found would not be pauper counties, without even an almshouse, and where there is one school now, there would be ten, and instead of innocence and ignorance, k n o w l e d g e would abound.

I mention this, first, because if a radical change in the existing conditions is brought about, it must be through the decision, determination and energy of the medical profession of Kentucky, and, second, to emphasize the fact, that in my judgment the disease is slowly and surely spreading throughout Central Kentucky. In the past two years I have seen in my clinical work in Lexington from five to ten cases of trachoma with corneal involvement where I saw one case five years ago. These cases come from the counties of Fayette, Bourbon, Scott, Woodford, Jessamine, Clark and Madison. This indicates to me that the disease is either on the increase or I am getting more than my share of the cases.

Several days ago Surgeon John McMullen of the U. S. Bureau of Public Health who has charge of the three trachoma hospitals in this State, gave me a synopsis of his report, made on September 1, 1914, which briefly abstracted is, of one thousand cases coming for treatment, of these the

Number of cases with impaired vision from trachoma, 50.3 per cent.

Number of cases blind from trachoma, 5 per cent.

Number of cases corneal opacity from trachoma, 24.5 per cent.

Number of cases corneal ulcer from trachoma, 16 per cent.

Number of cases of pannus, 29 per cent.

Number of cases photophobia, 19.3 per cent.

Number of cases of entropin, 13.9 per cent.

Number of cases trichiasis, 10.8 per cent.

Number of cases approximate cures of trachoma, 21 per cent.

Cases requiring secondary operation within six months, 15 per cent.

It is to be borne in mind that neither one of these hospitals has been in existence as long as one year. The one at Hindman has been receiving and treating patients for 300 days, that at Hyden 280 days, and that at Jackson 99 days, making 679 days for the three hospitals. Another important fact is, that only those come to the Government hospital or to either of my semi-annual clinics, who are not in such pain or whose vision is so impaired that they cannot work or do usual domestic duties. The dread, fear and superstition regarding hospitals and strange doctors and nurses, is with the greatest difficulty overcome to the extent that these "gentle folk" will consent to leave their home and loved ones and submit to treatment. The attendance at the out-door or dispensary of the Government hospitals has been 6687—total number of treatments given 7864, average daily attendance 37.

It is gratifying to know that Surgeon McMullen has had added to his corps of workers, Assistant Surgeon J. G. Wilson of the U. S. Public Health Service, who has been directed to proceed at once to the counties of Jackson, Laurel, Clay, Knox and Whitley and make a survey of the prevalence of trachoma in these counties, with instructions to examine a sufficient number of people in each county to determine the percentage of them that have trachoma, especial attention being given to examination of the school children, in order to obtain the general average of infection throughout the county. In addition to these instructions,

accurate records of these surveys are to be kept, and lectures are to be given in the schools and other public places, and in every way possible, further the educational (prevention) side of the work now being done in Eastern Kentucky. I regard the educational feature as most important, and it is to be regretted that so little of it has been done. In every school house, court house or public building where an audience of the natives can be gathered, lectures illustrated by pictures, charts and stereopticon lantern views should be given wherever and whenever possible. This scourge of the mountains is to be wiped out by the combined unified work of the medical man, trained nurse and school teacher.

The trachoma condition in Eastern Kentucky as described by Surgeon McMullen and myself has been confirmed by Dr. Herbert Harlan, of Baltimore, and Dr. F. Park Lewis, of Buffalo, N. Y., both of them, at different times spent a week at the Government Hospitals assisting and advising in the treatment. Their reports were made to Surgeon General Blue, of the U. S. Public Health Service.

The effects of trachoma are felt not only by the individual but also by the community in which he lives. The invalidism caused by the disease is liable to impose financial burdens—on that community, and the resulting blindness may render its victims public charges.

Finally, school children affected by the disease have their studies interfered with, their education will be more expensive, their power to earn a living will be permanently lessened, and through no fault of theirs they may become permanent charges on the State.

As the wide prevalence of infectious and contagious diseases among the people, notably trachoma and tuberculosis, depends largely upon the ignorance and indigence of the people, and absence of central and local organization in the administration of sanitary matters among them, the following recommendations are made:

(1). The economic status of the people should be improved. Improvement in such status is necessarily directed toward causing the people to become self-supporting so that at all times their food supply will be regular and sufficient. The people, therefore, should have closer and more practical supervision and encouragement in the tilling of their land and the raising of crops. In localities where agriculture is not profitable, they should receive similar encouragement and supervision in other occupations suitable to their needs and environment.

(2). Efforts should be made in greater degree to educate the people in personal and domestic hygiene and the means necessary to guard against contagious and infectious diseases.

(3). In combatting diseases, educational measures have been found to be most important and cannot be neglected. Such education should be more widely attempted by means of home-instruction, lectures, demonstrations, moving picture shows, and by any other means found to be effective.

(4). Greater efforts should be made toward the improvement of the houses of the people. Studies should be undertaken in the design of the cheapest and most sanitary forms of dwellings for the various climatic conditions in localities, and the people encouraged and aided, so far as practicable in the construction of such habitations. All dwellings built in the future should be in conformity with an improved design.

(5). Insofar as practicable each house should be restricted to the use of but one family, thus avoiding the overcrowding now so common.

(6). Hospital facilities should be provided in localities for the reception of people suffering from severe trachoma and in need of hospital treatment. Sufficient authority should be granted to require them to undergo such treatment when, from the condition of their eyes, they are a menace to the public health. Hospitals for this purpose need not be expensive, and most trachoma cases could receive outpatient treatment.

(7). In each infected sanitary district a dispensary or office, portable or permanent in character, should be provided for the treatment of cases of trachoma not requiring hospital care, and such dispensaries should be in charge of those qualified to administer treatment for diseases of the eye.

(8). A sufficient number of field nurses should be provided to administer, under the direction of the physician, home treatment and instruction to those who cannot be sent to the hospital or attend the dispensary.

(9). No children suffering from trachoma should be admitted to uninfected schools.

(10). Separate schools where practicable, should be established for trachomatous children.

(11). All boarding schools wherein trachomatous pupils are admitted should be provided with adequate facilities for the care and treatment of trachoma, such facilities to include the permanent services of a nurse trained in the care and treatment of diseases of the eye.

The disease is essentially a chronic one, with years, as a rule, intervening between the time of its incipiency and the terminal stage, depending upon the management of the case and whether the most appropriate treatment is administered or not.

In the beginning the diagnosis is difficult, often

time alone revealing positively whether it be a true trachoma or not. The terrible inconvenience that this disease imposes upon its victims as well as the suffering can hardly be conceived by those who are not actively engaged in its treatment. The patients may be afflicted for months, indeed, sometimes they wait months before consulting a physician, often until their vision is impaired and painful photophobia and lachrymation interferes with their work. In my work in the mountains I never make a positive diagnosis until I meet with the second stage. In this stage the palpebral conjunctiva is hypertrophied, studded with granules or has a raspberry appearance, indicating progressive deduction of the membrane, causing a rough uneven surface and the tarsal cartilage is noticeably thickened.

In this stage we have the beginning of pannus phlyctenular-keratitis and ulceration of the cornea. Gradually this passes into the third stage, in which the connective tissue has replaced the conjunctiva of the eyelids and the tarsal cartilage is in an atrophic condition, the result being that the lid is no longer held in its proper position, the lashes turning under and constantly irritating the already inflamed cornea, which mechanical action prevents the pannus from clearing up. Exudation into the cornea occurs and without very active and continuous treatment the patient must go the rest of his days with his vision partially or totally destroyed, a burden to himself and the community.

The prognosis of the disease in any stage depends on the patient himself and the facilities for giving the treatment which of necessity must be long, tiresome and painful. All agree that trachoma is a communicable, destructive disease, and yet we have all seen cases in which there has been an infection of one eye for several months or years and no precautions have been taken to avoid infection of the other eye, and yet the other eye has not yet been involved. Such cases as these make you think that there must be some condition of the conjunctiva in one eye that creates an immunity from the disease.

In photophobia, from whatever cause, atropia is used and mydriasis maintained. I prefer grattage to other operations because of less traumatism and reaction and it is usually just as effectual. In blepharospasm or blepharo-synechia, a free canthotomy or cantho-plasty operation is done, being careful to sever the tendon of the orbicularis. The edges of both lids are then kept wide apart by sutures fastened above and below by adhesive or collodion. Iodoform powder is packed into the cut surfaces. If triciasis and entropion exists they are corrected at the time of the canthotomy. From the time the patient is admitted to the hospital active and energetic local treatment is kept up every two hours night and day until marked improvement occurs, then every four hours. My most frequent and routine treatment used is dionin, 1 to 3 per cent., atropia, same strength, and 25 per cent. argyrol (freshly prepared). These three remedies are used every two hours at intervals of two or three minutes between each one. Two drops each of dionin and atropia are used at intervals of three minutes after which while the upper lid is held away from the globe the parts are literally flooded with the 25 per cent. argyrol. As soon as the pupil is completely dilated the atropia is used less frequently but dionin and argyrol are continued every two or three hours. Little or no irrigation is used, but instead the eyelids are separated and the tenacious, stringy mucous wiped off with a cotton swab before each treatment. Dionin has proved a most valuable synergistic adjunct on account of its analgesic and lymphagogue action. When the dionin begins to lose its effect and no longer causes redness and edema of the ocular conjunctiva, it is discontinued for several days, and a sub-conjunctival injection of saline solution is given. Two or three days afterward we can usually get the dionin reaction again and begin to use as before. If there is a dense pannus or slugish ulceration or phlyctenules of the cornea, very hot application of equal parts normal saline and boracic acid solution are made for thirty minutes in every two or three hours until desired results are in evidence. Injury is often done by continuing hot application too long, resulting in a lowering of the vitality of the parts. If improvement is not noticed in a few hours after discontinuing the use of the dionin and using the moist heat, I resort to application of 10 per cent trichloro-acetic acid or equal parts of iodoform and calomel to the ulcerated surface. No dressing or bandage is ever used, as these retain the secretions and soon form a septic poultice. The eyes are shaded by green celluloid shades and kept dry and clean with small mops of sterile cotton or gauze. Patients are not kept in bed, except for 24 hours after operation unless there are special reasons for doing so. Careful attention is given to the systemic condition. Inasmuch as many of my cases have had hook worm, the test for this is made upon admission and if positive, treatment is given at once.

DISCUSSION:

T. F. Wickliffe, Jackson: In discussing this paper I wish to say, that I have not heard a paper in years which I have enjoyed any more than it, and anything I may say must not be considered in the nature of a criticism in any way, because we all know that Dr. Stucky's work is as well known in the mountains of Kentucky as any other

man up there. When he said he won the love of those people he told you the truth. I wish to say regarding our hospital treatment in the mountains that the operative and other treatment is absolutely free. The United States Public Health Service does not charge anything for what they do for these people. But they must after operation, stay with us long enough for us to get them partially well, and this means from three days a week. Some of the worst cases are kept there for over a month. We do not believe in operating on them and allowing them to get out in the sunlight. If we do, they come back with iritis or some other complication. The eyes give them trouble unless they stay out of the sunlight. They are instructed that when they go home they must stay out of the sunlight most of the time. The youngest case of entropion I have seen has been in a thirteen year old girl. I do not know how old would be the oldest. The cornea clears up better in cases of entropion than in cases of trachoma without entropion. I have seen patients with entropion who could not see my fingers more than six inches. These cases are now taking care of themselves without asking the assistance of anybody and are making a living for themselves and families. In saying this disease causes poverty Dr. Stucky said many truthful things for I know of no people needing more help as they absolutely can not work for months or years at a time.

The youngest case of trachoma I have seen was in a fifteen-months-old baby. I have seen lots of babies all the time in the mother's arms, yet not have this disease, when the mother had a very active case of trachoma. Why, I do not know. Dr. Stucky, I feel sure, will have seen the same thing. This fifteen-months-old child had a marked case of trachoma. The oldest cases was sixty-eight years of age. As a rule, babies seem to escape the disease in some way. The mother will have it so bad that she cannot see the child, and with the tears all falling down from the photophobia, yet the baby does not have it. The longest case was forty-five years, the patient being now forty-eight years of age, and while she is rid of the disease she has got entropion, trichiasis, and corneal opacity and pannus, and is suffering from almost total loss of sight. She could not see my fingers with one eye, and with the other just a foot and a half. She refused to be operated, saying that if her eyelids were twisted, that God did it, and it was God's will for her to go blind, and that she would just have to submit to going blind. I never did get to operate on that woman. The cornea seemed in her case, and in a number of other cases to get so sclerosed, that they do not suffer like you or I. If we get the least particle of sand in our eyes it makes us wild. I am more sensitive than most people in that regard. I have seen a number of cases that have not complained of pain from this entropion, with the eye-lash right in on the eyeball. Unless we can treat all cases in the family, the cases we do treat will probably get reinfected. I have had two cases that did. One case was a boy whose father married a second time, and his wife refused to let the boy stay in the house and turned him loose in the mountains. The boy was in the most pitiful condition you ever saw. He told me he had never had a bath all over but once before in his life. We got him well, and sent him home. The boy got infected again, came back, and got cured a second time. That has happened in a number of cases in our experience in the mountain hospitals, and unless we get hold of all cases in the family it is wasting time to treat them because they get reinfected. We are trying to save the sight and the people. It is only trachoma which is infectious we are trying to handle. After it reaches the cicatricial stage it is not infectious. I believe this disease may lie dormant in a case for years and then flare up again. From the time they are little children, they may have the disease, and when they do some work that gets dust in their eyes, it will provoke this acute flaring-up of the disease that brings them in. Nine times out of ten if you ask them how they got it, they will say they got it from gathering fodder. They believe that causes them to have sore eyes. If they do not tell you that, they will say they got it from the measles which they had three or twenty years ago, and they say their eyes have not been well since. It is hard to teach them that the disease is caused by a germ and that they infect one another. It is hard to teach them that they do not contract it from having had the measles or from gathering fodder. They do not realize how they got it unless we teach them that the most ordinary way of getting it is from the common towel. If you went through the mountains and night overtook you, they would take you into the house. They do not ask whether you have the disease. You are perfectly welcome to share the house with them, notwithstanding the fact that you may have the disease and they may not. The next morning they will give you a clean towel. If you have the disease and wipe on that towel, the members of the family, when they wash, will wipe on the same towel, and so the disease is spread in that way. If you ask them why or how they got the disease, they will tell you they do not know, but we know that they got it from the towel that strangers use in traveling around in the mountains. It is that more than any other one thing. These people are so kind that they will give Dr. McMullin, myself, and the head nurse beds while they will sleep in the kitchen on the floor. There

are mighty few places outside of the mountains, where people will sleep on the floor and give their beds to strangers.

Isaac Lederman, Louisville: I want to pay my tribute to Dr. Stucky personally and to his work. I think the general profession is not in a position to appreciate what Dr. Stucky has done for the mountain people of Kentucky as is the specialist who comes in contact with this disease. In Louisville we do not see trachoma as Dr. Stucky does. We see real trachoma; we see a few cases from the mountains, but we do not see the numbers of them. And yet we see a great many more than we ought to. In his remarks he stated that either trachoma was on the increase in central Kentucky, or he was getting more than his share of the cases. He is getting more than his share because he is becoming well known throughout Kentucky, and from a selfish standpoint he is welcome to them. We know the difficulty which attends its cure, and we know its ravages. We know what the disease means, and so far as Dr. Stucky's remarks in that connection are concerned, there is no reason for discussion. The movement for the eradication of trachoma, I believe, must be carried farther than the treatment. I firmly believe that the social work which should follow up the treatment is more important, if I may be permitted to say so, than the treatment itself.

Dr. Wickliffe brought up the question of the use of the common towel. The wash basin, the common soap and common towel, sleeping in the same bed, as all these children do, piled in together, are the causes of the propagation of trachoma. I do not believe it is carried by children being in the vicinity of one another. I have taken the stand personally that the schoolhouse, especially the modern city school, with its frequent inspection, is not the source of danger that the home is, and that the constant association of children in their play may be. So I want to bring out that one point, giving Dr. Stucky full credit for all work he has done. I believe the movement must not stop there, and I think Dr. Stucky believes that trachoma is going to be controlled through the district nurses going to these homes and following up the treatment. The same principle should apply to the management of the disease in the city. Instead of merely prohibiting these children from attending school, which is not sufficient, efforts at reform must be carried to their homes, and in that way we will sooner or later eradicate the disease.

Arthur T. McCormack, Bowling Green: The trachoma situation, as revealed by Dr. Stucky's labor and by the follow-up work stimulated by the United States Public Health Service in the mountains of Kentucky, is one of the most serious health problems with which we have to contend. As has been indicated, the problem is a much larger one than the mere treatment of the disease. It is a problem involving whole communities that live in the mountains, that live in the Blue Grass region, and it not only interests the State of Kentucky but the nation. This government has been spending large sums of money in excluding suspected or suspicious cases of trachoma from entrance to our ports. More cases of trachoma have been actually operated upon in Kentucky in the past year than have been excluded from all ports of the United States in any one of the last twenty-five years. This gives you an indication of the tremendous problem involved. There is ample authority in the statutes for the eradication of the disease in the existing boards of health to-day. Any county board of health to-day has the authority in cases of any communicable disease to bring the infected population under prompt and effective treatment. The board of health has the authority to employ such experts as are necessary to carry on this treatment. This power has been upheld by the Court of Appeals and by courts everywhere, but it is necessary to present such reports as these before the people in order to have public sentiment behind us to get the consent of the Fiscal Court to make these appropriations in the various counties. They can be gotten with average magistrates provided the purposes of the work are made plain, and then the work is done well and economically.

So far as trachoma is concerned, up to the time Dr. Stucky made some of these investigations and reports, we did not know very much about its existence in the State. The average magistrate, who naturally does not immediately hand out all the money in the county as soon as he is informed that trachoma is prevalent, knowing as little or less about the character and danger of the disease as we doctors did a year ago, must be educated as you and I were educated. The reason for the exclusion of these cases from school is because we want the people to appreciate the the necessity for treatment. They understand when excluded from school, because the desire for education is very great. There is some danger of contagion in any contact with these cases. Personally, I would not want a child of mine to sit in the same seat with a child who had the disease in mild form, however well educated or trained may be the child, in order to attempt to prevent the spread of the disease from the other child. I do not believe these cases ought to attend school. Not only on account of the danger of spreading the disease, but because I do not believe a child with an acute, subacute or chronic trachoma has its eyes in such a condition that it

can read printed matter in the average school books or understand it even if it did read it. I do not think there can be the slightest objection to excluding these children from schools whose eyes are suspicious of being trachomatous. It is said that six or seven weeks are necessary to cure the disease confounded with trachoma, and such cure of acute eye diseases is of the utmost importance to the child. With the average education, if a child should lose six or eight weeks, it does not lose much. I doubt if such a brief absence could affect seriously the life of any child with sore eyes that studies in the common or high school, and even if the child should lose a whole year and get well from disease of the eyes, it would be better off than if it attended school without knowing what was the matter with the eyes, even if it could be taken for granted that it did not endanger the eyes of other pupils.

J. A. Stucky, (Closing): We have something encouraging from Bowling Green. Dr. McMullin sent me a yellow circular saying "Trachoma cured by Dr. Munyon's famous Mexican Eye Treatment." This medicine is made in that city. I immediately wired him to send me some of the medicine, and I have a sample of it in my pocket. I dare say that it contains some cocain. The claim is made that trachoma can be cured with these eye-drops.

Dr. Wickliffe spoke about trachoma in babies. I do not think I have ever seen a case of trachoma in a baby under two years old. If I have, I did not recognize it. The majority of these people think that trachoma is a dispensation of Providence. I am glad Dr. Wickliffe brought that point out. They are not irreligious.

I think the cases of acute exacerbations in the chronic cases ought to be put in a hospital and treated as actively as we would treat gonorrheal ophthalmia. If you are going to exclude one, exclude the other. When I have a case that is treated every two to four hours, night and day, as I brought out in the latter part of my paper, "there is something doing," and the results are soon apparent.

Dr. Lederman emphasized one point I brought out in my paper, and I think you will agree with me, and that is the three-fold importance of the medical man, trained nurse, and school teacher in the eradication of this disease. They should combine and work as one person.

Leslie L. Robertson, M.D.

(1867-1924)

DOCTOR Robertson, the son of a physician, Doctor William H. Robertson, was born near Minerva, Mason County, Kentucky. Leslie L. Robertson attended the University of Kentucky in Lexington and received his medical degree from the University of Louisville Medical Department in 1888. After an internship in New York City, Doctor Robertson began the practice of medicine in Maysville in 1889, but shortly moved to Middlesboro, Bell County, Kentucky. He had an extensive private practice and was also surgeon for the Louisville and Nashville Railroad and the Southern Railroad. Doctor Robertson was an influential citizen in Bell County and active in the County and the Kentucky State Medical Societies.

This report recommending prompt operation for definitive treatment of gun-shot wounds of the abdomen is indicative of the foresight and understanding of the author. Even at the end of World War I, routine abdominal exploration was not recommended or practiced as definitive treatment of gun-shot wounds of the abdomen.

GUN SHOT WOUNDS OF THE ABDOMEN.* **

By L. L. Robertson, Middlesboro.

The treatment of gun shot wounds of the abdomen by laparotomy is one of the latest developments of modern surgery. Up to 1885, according to Parkes, only six operations for this class of work were recorded. Coley tells us that the first laparotomy for gun shot wound of the abdomen was by Boudens in 1836. He resected eight inches of a small bowel and united the ends by Lembert's sutures. After the death of the patient three days later, an undiscovered wound of the ceacum was found. Among the most remarkable laparotomy for gun shot wound was performed by the late Dr. W. T. Bull of New York in 1885 where seven perforations were found and closed, the patient making a complete recovery. This subject was forced into prominence by the interest manifested in connection with the murder of President Garfield by a gun shot wound of the abdomen. The usually hopeless results of these injuries when untreated and the success of certain operations combined with the general improvements in modern abdominal surgery have now resulted in placing the treatment of gun shot wounds of the abdomen among justifiable and beneficial operations. And American surgeons have contributed by far the most important part.

A bullet from any sort of firearm at close range will in most cases cause deep penetration. It is rarely possible to get true information as to the course of the bullet from the position which the wounded person held when the shot was fired. For all practical purposes the size and rapidity of the bullet may be ignored, although a large and nearly spent ball produces more extensive injuries than a small or rapidly moving ball, yet the effects of either are quite serious enough to greatly endanger life and make an urgent claim for operative treatment. It has been truly said that the tendency of gun shot wounds of the abdomen is towards death. In a great majority of cases death is due to a form of peritonitis which is usually described as septic. No doubt the peritonitic fluids are septic but it is doubtful if the death is owing to true blood poisoning rather than to severe shock. In about 90 per cent. of the cases attacked with peritonitis, death takes place within forty-eight hours. It is true that the peritoneum has a limited power of disposing of septic fluids, but this power of the peritoneum has an infinitessimal influence in lessening the death rate from this class of injuries. Even if there has been a moderately perfect plastic closure of the perforation the edges of a bullet wound are so liable to undergo sloughing that a secondary perforation usually takes place. A separated slough cast loose into the cavity has great danger of its own. A slough of the mesentery which cannot fall into the bowel is more dangerous than one on the intestinal wall.

Bleeding is, in itself, rarely fatal unless the

*Read before the Bell County Medical Society.

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bullet should perforate one of the large blood vessels, but the extravasated blood when infected by free visceral fluids produces extreme septic inflammation and so adds to the danger. A few deaths have been caused from loss of blood through perforation of some of the large blood vessels. This is more likely to occur from wounds involving the solid viscera and their vessels than from injuries to the hollow viscera. For instance, presence of blood in the urine indicates, according to the position of the wound, injury to kidney, ureter or bladder, but it is possible you may have injury to any of these organs without the appearance of haematuria. Shot wounds of the kidney are not so dangerous as is generally supposed. According to Edler death most frequently results from pyaemia accompanied with peritonitis and suppuration. Recovery is usually slow on account of the complication of urinary extravasation. Of the uncomplicated shot wounds of the kidney 85 per cent, according to Edler, get well.

Wounds of the omentum are occasionally attended with free bleeding which may form a large haematoma between its layers. In such a case complete amputation of the omentum above the site of injury would be the best treatment. A perforation without bleeding should be excised and the opening closed by continuous suture to prevent gangrene.

Wounds of the liver are by no means necessarily fatal. A good per cent. of these cases will recover. Suppurative inflammation is most frequent cause of death due to foreign bodies in the wounds, particularly to splinters of rib. You should look for foreign bodies and remove them if found. Hemorrhage is the cause of death in some cases. The wound should be cleansed as thoroughly as possible. Bleeding must be checked either by the insertion of deep cat gut sutures or by plugging the wound with gauze. Murphy, in a successful case, employed suture alone.

Wounds from the spleen cause death almost invariably by hemorrhage. Suppuration is rare, and then mostly from the presence of foreign bodies. The checking of hemorrhage is difficult and plugging the wound by gauze is best. Should this fail, primary removal is indicated. The results of removal for injury are more favorable than for disease.

Wound of the gall bladder is almost certain to cause death from extravasation. Under the best palliative treatment death almost inevitably takes place. In shot wounds of the large intestines the prognosis is more favorable.

Shock is frequently mentioned as an invariable sequence of perforating wounds of the viscera. While in some cases it is an exceedingly variable symptom, frequently it is marked in unimportant cutaneous wounds. I recall a case of a man shot a few years ago. The ball entered on the right side of the abdomen and followed the sheath of the abdominal muscles and was removed on the opposite side of the abdomen. The patient had a profound shock but the bullet never entered the abdominal cavity. In some cases it is simply nerve prostration from terror. In perforation of any of the abdominal viscera a majority of the cases will be followed by shock more or less severe. One of the most important symptoms is a feeling of nausea frequently accompanied with vomiting. This is not common with false shock while in numbers of cases of undoubted perforation it is present in more or less degree. True abdominal shock from extravasation of fluid into the cavity is generally very pronounced and more or less severe.

An important practical question is when is the best time to operate. In a general way it may safely be said that operation should be performed as soon as possible after it has been made sure that there is perforation of peritoneum. Coley reports 39 cases operated on within twelve hours, 18 recovered, while 22 operated on after 12 hours, only 5 recovered. The chance of recovery would seem to be greatly increased by early operation. Symptoms should not be treated for they are often misleading. If there is profound shock the operation may be put off while the patient is watched closely and treated for an improvement which would justify operation. The possibility of the shock being due to hemorrhage must not be overlooked. This, as in many other conditions, must be left to the judgment of the surgeon. It is impossible to provide specific or absolute rules.

Before operation the abdomen should be thoroughly cleansed with soap and water and shaved and painted over with iodine. The instruments are the ordinary ones used for abdominal section, with the addition of four or five intestinal clamps. The incision in the majority of cases should be made in the median line. There is no doubt that it affords more space for a general exploration of the whole cavity and its contained viscera, while on the other hand there are cases where an incision in the median line is not indicated. What is to be the exact line of incision it is impossible in general terms to indicate.

The length of the incision must be regulated by the thickness of the abdominal wall, but make the incision sufficiently large so you will have room to work. When the abdomen is opened make certain as to the fact of the perforation. Any blood clot which obscures the field of operation is mopped up gently, a systematic examination of all the viscera which lie in or near the track of the ball should be thoroughly made. If there is much hem-

orrhage the source of it should at once be found before doing anything else and the bleeding point temporarily secured by forceps. While an opening in the bowel that is discharging feces is being closed, no definite order of procedure can be laid down—the most urgent thing attended to first. A survey of the parts is made when the dangerous hemorrhage or abundant extravasation has been checked and the full extent of the injuries is finally ascertained. A moderately severe contusion may be doubled inward and Lembert's suture used or a continuous suture placed in the healthy bowel beyond it so that if it does become gangrenous the slough will be discharged into the lumen of the gut and cannot get into the general cavity. In cases of perforation of the bowel Lembert's sutures will be the best. For a small perforation a continuous suture will be sufficient. A multiple perforation of a small piece of bowel may require a resection. I would like to report a case of a child 14 years of age who was accidentally shot in the abdomen by her brother, playing with a pistol. The bullet entered the abdomen about an inch from the median line. The accident occurred about 7 o'clock in the morning in a neighboring town. The child was sent to me in the afternoon arriving here about 6 o'clock. She was immediately taken to the hospital and upon examination I found her abdomen was very much distended and extremely tight. Pulse very rapid. The child was more or less under the influence of opium given by the nurse with her. An immediate operation was advised and as soon as the operating room was ready she was anesthetized, an incision made in the median line, the peritoneum opened. We found the abdomen full of blood which was cleaned out as quickly as possible, the bleeding points clamped with forceps and on examination of the intestines we found three perforations of the bowel which were closed by silk sutures. And just here I would like to state that round worms in the bowels were protruding through the opening in the gut. They of course were removed with pieces of gauze before the perforations were closed. On further inspection we found a multiple perforation of the small bowel which was most impossible to close, so we did a complete resection of about four inches of small intestines, using a Murphy button. The abdomen was cleansed as best we could and closed, leaving two large drainage tubes in the abdomen, the patient removed from the table and placed in bed in the Fowler position, with hot water bottles. The pulse was very bad. She was given transfusion of saline solution at once and continued at intervals for two days. During the first two days her condition was extremely rocky, but from that time on she made a good and complete recovery, leaving the hospital in about four weeks.

Benjamin Prince Earle, M.D.

(1846-1918)

DOCTOR Earle was born at Barren Plains, Robertson County, Tennessee. From 1867-1868, he apprenticed himself to Peter J. Bailey, M.D., of Keysburg, Logan County, Kentucky. In 1868, he attended one session at the University of Louisville Medical Department. The following year he attended lectures at the Hospital College of Medicine from which he received his M.D. degree in 1869.

He began the practice of medicine at Charleston, Hopkins County, Kentucky after graduation and continued there for nearly 50 years.

This address is an account of the problems faced in the practice of medicine in Kentucky nearly one hundred years ago.

THEN AND NOW.* **

By Ben P. Earle, Dawson.

CONDITIONS FIFTY YEARS AGO AND IN THE CHANGING PRESENT.

The paper here presented was given before the Hopkins County Medical Society and is repeated by request with the hope that it will contain entertainment and perhaps instruction for those of the younger generation whose memories do not span the past half-century of improvement, progress, and change. The conditions that here refer to one county were common to all the counties of Kentucky and throughout the nation. It is well to pause at intervals and look backward at our footprints on the sands of time.

In Hopkins county, fifty years ago, there was no Earlington, Morton's Gap, Nortonsville, Mannington, White Plains St. Charles, Hanson or Dawson Springs. Dalton consisted of one small store, church building, schoolhouse, and blacksmith shop. The only towns in the county were Madisonville, Nebo, Charleston, with a few small stores about over the county.

We had not more than half the public roads we have to-day and they were maintained on the old "hand system." They were very poorly worked. One third of them were so narrow that when two vehicles met one would have to sidetrack and stop while the other passed by. I doubt very much if there were as many as 150 carriages, buggies, or other pleasure vehicles in the entire county, and of course such a thing as a rubber tire had never been dreamed of. There were no railroads. Mails were conveyed through from town to town on horseback or by hack.

Mail service consisted of not more than a half dozen postoffices and there was but little mail matter. In 1869 when I located in Charleston, we received our mail from the Madisonville office, fourteen miles away. The people around Charleston had an understanding with the postmaster and among themselves that any one of us who happened to be in town would bring out the mail for the neighborhood. By this means we got mail about once a week. Then, if we saw a newspaper that was not more than a week old, we had fresh news. Now, we want a morning and an evening paper. At this time there was received for the whole Charleston district perhaps as much mail matter as now comes to my home. A man then who was a subscriber for a weekly or a monthly newspaper was looked up to as a superior person, and the doctor who "took a medical journal", why, he was expected to be about equal to the doctor who now takes a post graduate course. There was no effort whatever toward having a medical society.

The status of physician's instruments and libraries may be inferred from the fact that in 1868, Drs. Dempsey, E. G. Davis and Pritchett amputated the forearm near the wrist and were therefore regarded as the leading physicians of the county. After getting all their instruments together, to perform this, then unusual, operation, they found it necessary to borrow some instruments from other doctors. There wasn't a hypodermic syringe in the county, in fact, but few, if any of the doctors would have known what he had

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found if he had picked one up. I attended my first course of lectures in 1868 and 1869 at the University of Louisville and out of the 230 matriculates, not ten had ever seen one. No one had ever heard of a fever thermometer, and when the first ones were sent out they did not "self-register," so, when you used one, you had to look quickly for the mercury would begin to fall as soon as you removed it from the patient. There was not a microscope in the county. Stethoscopes were a curiosity. The only drug stores in the county were three in Madisonville, and the entire stock of these three would not equal one ordinary drug store in a small town. The doctors all kept their own medicines and wrote very few prescriptions.

There were no telephones, or telegraphs. All calls were by courier, either on foot or on horseback. And it was not at all uncommon for a doctor to receive a call and postpone answering it until the next day. During what he called the "sickly season," from July to December, it was not at all uncommon for a doctor to be 24 hours behind with his calls, in fact, many of us had to do our work by neighborhoods, so that when we started in the morning we would do one section and pass into another, and if we received a call back to the first section, we had to wait until we could finish up in other places and get around again. It was no uncommon sight to see two or more couriers keeping up with the doctors, until he could reach their sick people. I remember on one Sunday afternoon after having ridden 40 miles with several calls yet to make, I found, on arriving at home, two young men awaiting me with a call to go to see a lady ten miles away who they said was very ill, sick unto death. They had been waiting at my house for several hours. I had to tell them it would be at least 24 hours, if no other work accumulated, before I could reach her. So they left with my promise that I would be there as soon as possible. Just imagine, if you can, people waiting for a day or more for a doctor to get around. Now if you can't come right away, they call another and another, until one is found who can come, and come in automobile style.

Our means of diagnosis, then, consisted often of a poor history of the case, the pulse, the tongue, poorly done auscultation, and percussion, just a sort of general inspection. Now we have the X-ray, not only to show that we have a fracture, but the exact nature and extent of the fracture; not only the presence of a foreign body, but its exact location and character. We no longer have to depend on the inspection for anemia. We have the blood count; no longer the resistance of the arteries, we now figure the blood pressure. These and many other things enable us to form a more correct diagnosis. We no longer grope in darkness as to tuberculosis, typhoid, pneumonia, malaria, as to whether there are worms or not, we have the positive means of finding out. Then we were in happy ignorance of the "germ theory." Now we have only to catch the specific germ and administer the specific dose that is his special poison.

Then no requirements were exacted of the prospective medical student, anybody who had the price of tuition could enter. Now one must have not only a high school diploma, but must have two years college work. Then two terms of four or five months each was all that was required for graduation. Now it takes five years of seven months each. And after graduation, one is still required to pass a rigid examination before a State Board, before being allowed to practice. Then one could enter the practice without ever attending medical school at all. While the matter was then too lax, it is a question, if the pendulum is not swinging too far the other way.

I was taught then that to wound the peritoneum was almost certain death. Now the peritoneum is cut at any desired point, repaired, and all is well. Almost every part of the anatomy is operated upon now with good results following. Our professor on surgery spent an hour then in teaching us the difference between sanious and laudable pus. Now we are not to have pus at all. The amount of surgery done and required to be done has increased enormously. Much of this is brought about by the increase in railroading, mining, manufactories, the use of automobiles, etc., while the knowledge of antiseptics enables the surgeon to enter the internal cavities with impunity, removing almost any part and repairing that which is left.

Then sanitariums were only to be found in the very large cities and only few there in comparison with the present. Now almost every town of two thousand inhabitants has one or more hospitals, many of them well patronized. Then there was no such thing as a board of health or health officer appointed to look out for epidemics and use special effort and care to suppress them. Now all towns of two thousand or more inhabitants, all counties, and the states have their board duly appointed to look after this part of the community business. In many counties and towns a physician is appointed who is required to give his full time to protecting the health of the citizens. Weekly medical inspection of school children is being urged almost everywhere.

Sanitation as a science was then not thought of. Only such ideas as any individual doctor might have were taught and crudely at that. Now a strong effort is being made to have everybody taught sanitation and all means of prevention of disease in a more or less scientific way. And the concensus

of opinion is that much good is being done thereby.

Trained nurses, God bless them," were not thought of fifty years ago. Such nurses as we then had were in hospitals as care-takers of the sick, and all their knowledge was gained by experience. While many of these practical nurses became quite proficient, now we have schools in every considerable town where persons wishing to enter this field are taught to do their work in a much more scientific manner. Now we feel that they are indispensible in the sick room and in all cases of both major and minor surgery.

Then we had but few men who were considered specialists and none, perhaps, who were doing special work exclusively. Now we have them, not only in the centers of population, but in almost every town and hamlet men are doing special work. All the subjects of medicine and surgery are being specialized.

Fifty years ago we had but few remedies and we had to carry our outfit in our saddlebags. Then, no matter what the diagnosis was, we gave calomel, quinine, ipecac, morphine, and rheubarb; these with a can of cantharidal ointment to blister with and whatever domestic remedies we could pick up, were the armamentarium with which we were equipped to fight disease. Then, with many doctors, bragging and hectoring over their patients was resorted to. Bluffing, loud-sounding pompous talk is no longer taken for knowledge, but the physician must show by his work that he understands his business. The doctor who uses intoxicants is no longer respected. And the use of profane or uncouth language in the sick-room is no longer allowed. So far as my knowledge goes, no doctor is now ever guilty of these objectionable things. The morals of the profession are very much improved in every way. I congratulate all you younger men on belonging to a profession of which the standards are the highest, which is increasingly capable of doing the highest service to mankind, and which *was* forever glorified in the Master's sight in the four words of the greatest of the Apostles, when he said, "Luke the beloved Physician." May you all bear worthily the honors of our calling, pass on to posterity whatever is good, improve on our mistakes and overlooking any of the shortcomings of our generation, give credit to the noble pioneers of our profession who, amid such difficulties as I have tried to portray, dug deep the foundation for the enduring structure we have to-day. The work of 50 years ago was but a preparation for to-day. In looking back, remember that you, too, will look back on the wonderful inventions and improvements of the present as crude and clumsy. It is true in every generation:

"The old order changeth, yielding place to new,
And God fulfills Himself in many ways,
Lest one good custom should corrupt the world."

Timothy Thomas Gibson, M.D.
(1884-1937)

BORN at Gibson Station, Lee County, Virginia into an old Virginia family, he received his early education in the public schools in Virginia. After attending college, he studied medicine at the Hospital College of Medicine (Louisville), Medical College of Virginia (Richmond, Virginia) and the University of Louisville School of Medicine, from which he received his M. D. degree in 1909. Following graduation, he studied diseases of children under Doctor Phillip Barbour in Louisville and also graduated in pharmacy.

Doctor Gibson first practiced briefly in Bell County, Kentucky at Shamrock, but for the remainder of his professional experience, he was located at Middlesboro. Doctor Gibson was one of the pioneers in this state in the use of the new x-rays and in the application of physical therapy methods in the care of his patients. He was President of the Bell County Medical Society in 1921 and an active member of the Kentucky State Medical Association.

The following paper, "Worms", is reprinted here because it tells, briefly, the story of another of the major public health problems in the United States that was conquered in the early decades of this century. In this paper, Doctor Gibson suggests the positive relationship between Pellagra and nutritional deficiency which was not experimentally produced until 1919 by Joseph Goldberger and his colleagues in the United States Public Health Service.

WORMS.* **

By T. T. Gibson, Middlesboro.

Conditions of health as I see them among the mountain people as a whole, after seven years of general practice, in the hollows, along the creeks, on the mountain sides of Cumberland Range, in well built houses, and log cabins, where the fence corners and chimney corners are the principal toilets, and the mountain streams are the open sewers; I have found our old friend Hook-worm, in company with other worms, to produce symptoms of almost any disease, between falling out of the hair and ingrown toe nail. Patients who present a typical line of symptoms of tuberculosis, such as temperature, loss of flesh, night sweats, typical cough, poor appetite, increased pulse rate and other conditions described as tubercular symptoms; of this kind of patients I invariably make an effort to secure a specimens of feces, and of those from whom I have been successful in securing this specimen, and having the above mentioned symptoms, 100 per cent, sent to the State Laboratory, Bowling Green, have returned with an affirmative answer of hookworms, with many times in company of other worms.

Patients presenting the above symptoms, both with and without laboratory examination I invariably give them thymol, sometimes also santonin followed by an iron and arsenic tonic, under this treatment 100 per cent of cases treated the tuberculosis symptoms disappear. One case in which I was unable to get a State laboratory specimen, I used iron and arsenic tonic first, with but little results. I later gave to this patient thymol to remove worms, followed by iron and arsenic tonic with excellent results, and in the patients' own words: she passed lots of little short worms. Stomach trouble in the mountains is a great bugbear to our mountain people, and without thymol to remove worms, the stomach specialist would get more of my patients, but by its use most of them go along their way rejoicing, without having to swallow the stomach tube. In gall-bladder colic after the initial hypodermic for relief of pain, magnesium sulphate will give relief next to that thymol for the removal of worms, followed by sodium succinate, tincture nux-vomica, arsenic and magnesium sulfate will give relief next to that of a knife. One patient who had pneumonia and after it had disappeared was eating without gaining much strength, would not get out of bed on account of pain in right side, near upper border of liver. (By the way, he was my first patient to treat for hookworms). After getting an affirma-

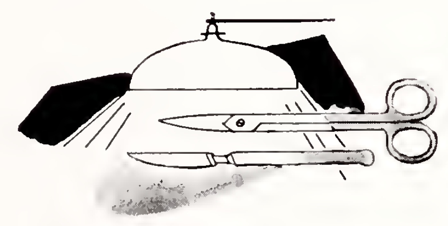
* Read before the Bell County Medical Society.

** Reprinted from *Ky. Med. Jour.*, No. 3, Vol. XVI, March 1, 1918.

tive report from the State Laboratory, I gave him thymol for the removal of worms, and in three days pain was relieved, and he was playing with other children in the yard. When I had been trying to get him out of bed for more than a week, telling him he was all right now, and that there was nothing the matter with him to keep him in bed but laziness.

Pellagra, the awful, dreaded disease, to my mind, is nothing more than of a starvation disease, caused in many instances by such an overload of worms, that the nutritive carrying qualities of the blood are so destroyed, or interfered with to such a great extent that the system is starving for the very food that the patient eats, but is being passed on without being distributed to the body as food for which it was intended. By the use of thymol for the removal of worms, followed by iron and arsenic, to repair the blood and lift up the folded papilla of the intestinal lining, I have had but very few pellagra patients to fail to improve greatly under this treatment.

After watching the examinations of the local exemption board for a couple of days, it is my belief that 75 per cent, of those in the mountains who fail to pass on account of underweight, should be given thymol for removal of worms, and put in an annex to a cantonment, for light drill and military duty and inside of three to five months, they would make husky soldiers, and ready for soldier duty. Those who are considered doubtful by the examining boards, but giving the Government the benefit of the doubt, by sending them as certified soldiers should not be returned home by the cantonment physician, until he has given him a thorough round of worm treatment and a chance to recuperate from what the worms have destroyed. This rule would hold good all over the mountain section with which I am best acquainted. I am satisfied it would be well to hold to it over most any territory, especially the South, neither should the North be slighted along these observation lines.



Burrell Clifford Wilson, M. D.

[1875-1946]

BURRELL Clifford Wilson was born 10 April 1875 at Atlanta, Georgia. He received his M.D. degree in 1899 from the Atlanta College of Physicians and Surgeons. Doctor Wilson served as a County Health Officer and at various times had been associated with the Florida and Kentucky State Boards of Health. On 22 February 1946, he died of heart disease at the Henry Watterson Hotel, Louisville, Kentucky.

A severe influenza outbreak occurred at Bowling Green, Kentucky on 22 September 1918, conveyed by a battalion of troups en route to Camp Zachary Taylor. In less than one week, there were over 6,000 cases resulting in 150 deaths in the city and county. Within ten weeks after these same troops reached Camp Taylor, there were over 13,200 cases, 815 deaths, in this Camp alone.

Doctor Wilson—at that time Acting Assistant Surgeon, U.S. Public Health Service, Bowling Green, Kentucky — observed and treated thousands of cases. It is on the basis of this experience that the following article was written.

MY EXPERIENCE WITH THE INFLUENZA IN KENTUCKY.*

B. C. Wilson, Acting Assistant Surgeon,
U. S. Public Health Service,
Bowling Green, Ky.

My activity in the midst of the influenza epidemic, from the beginning of the epidemic at Camp Taylor and later in numerous counties throughout the State, having afforded the opportunity to observe and treat thousands of cases, and to compare notes with hundreds of doctors in the field, forms the basis from which these conclusions are drawn.

OTHER GREAT EPIDEMICS AND PANDEMICS.

Second only to the present pandemic in extent and disaster, was the pandemic of 1890 and 1891, the infection then as now being a world disease, brought to the country probably from Russia, it was marked by the same tendency to spread rapidly along lines of travel at first attacking the large cities, then the smaller centers and the country districts. The greater facilities for travel, with more intermingling of the people and the massing of large bodies of men in the military camps having probably caused the present epidemic to spread even more rapidly than that of 1890 and 1891. Except for the seasonal difference —the epidemic of 1890 and 1891 being a wintertime disease—essential characteristics of the disease then and now have in almost all respects been identical.

It is of interest to note that the present pandemic having begun in Spain in the spring of this year and attacked a large majority of the population of that country at that time, that reports at this time indicate that the epidemic has recurred in that country even in a more serious form and is again spreading rapidly over the country.

Likewise in England where the epidemic prevailed during the early summer the disease is now prevailing anew.

The short period of incubation, 48 to 60 hours, and in many instances the common source of infection, resulting in entire families and in many instances, entire communities being stricken at the same time, gave no opportunity to prepare for the situation. The epidemic in many communities

* Reprinted from *Ky. Med. Jour.*, No. 12, Vol. XVI, December 1, 1918, pp. 565-568.

came as an explosion, swamping everything in its path. Neighbor was unable to render aid to neighbor and the great scarcity of doctors and nurses because of the war, made it impossible to meet the situation with adequate medical attention and nursing. The enormous task of getting the situation in hand was accomplished by the State Board of Health actively assisted by the United States Public Health Service, the American Red Cross and the State Council of Defense. Effective relief work was accomplished by sending doctors and nurses to the needy places, organizing emergency hospitals and keeping in touch by telegraph and telephone at all hours with exact conditions in the stricken communities. Such organized and effective efforts on the part of our public health officials, relieved much suffering and saved many lives.

WHAT IS INFLUENZA?

That the present epidemic disease is not "Spanish" influenza, any more than it is "American" influenza, but that it is la grippe or influenza in pandemic form of greater virulence and greater tendency to fatal pneumonia complications than previous epidemics of la grippe, is conceded by the best observers. That it attacks the young rather than the old, especially those under thirty years, and that in many instances where those over thirty year were attacked, it was usually mild or abortive, would probably indicate a degree of immunity, acquired by those over thirty years by virtue of having had the disease during the pandemic of 1889, 1890 and 1891. Whether the disease is caused by the Pfieffer bacillus of influenza alone or by mixed infections is not positively known, but that the principal habitat of the infective agent at the outset is in the nose and throat and contained in the secretions therefrom, there is ample evidence.

"Three Day Fever."—The overwhelming majority of all cases uncomplicated ran a temperature of from three to seven days, and many cases without pulmonary complications the temperature persisted for ten days. The fewest number of cases ran a temperature of only three days. Temperature subsided in almost all cases on the third or fourth day, by pseudo-crisis, and profuse perspiration, with a secondary rise of temperature on the succeeding day which subsided by lysis on the fifth to the tenth day. Temperatures in uncomplicated cases were rarely higher than 103 and pulse rate rarely over 100. Sneezing and coryza were not always observed as an early symptom, but increase in temperature, were always present in the beginning stage of the disease. The influenza "facies" was almost characteristic. Diarrhea was observed in a large number of cases as a symptom, but dizziness and aching of the head and limbs in other cases was doubtless due to over purgation. Complete loss of appetite was observed in nearly all cases from the beginning. In many cases pronounced toxemia was a prominent symptom and added to the gravity of the disease and the tendency to complications. The disease was especially marked by extreme prostration and slow convalescence, many patients remaining weak with loss of tone for weeks succeeding the attack. Relapses did not occur, but many patients who failed or refused to remain in bed for a sufficient length of time came down with broncho pneumonia and died quickly, sometimes within a few hours of the onset.

COMPLICATIONS.

The most serious and frequent complications were bronchial pneumonia. A few lobar pneumonias were observed. The latter cases frequently recovered. The bronchial pneumonias were overwhelmingly fatal. More children recovered than adults. The most frequent and early symptoms of a complicated pneumonia was a rise of temperature on the fifth to eighth day, followed in a few hours by rales in the chest, usually beginning at the base of one or both lungs, posteriorly. In the fatal cases the disease crept from one portion of the lung to another filling the air spaces until rales could be heard in all portions of both lungs. Air-hunger was a prominent symptom in many cases, due to the mechanical impossibility of getting sufficient air into the lungs to sustain the patient. All fatal cases of pneumonia were toxic from the beginning and the larger number were delirious throughout. The heart muscle in the larger number of cases remained fairly intact, the patient dying from the extreme toxemia or respiratory failure. Temperature in the fatal cases were high in the beginning, but were marked by gradual decline as the disease progressed, with a resultant low temperature for several days or hours preceding death. As the temperature subsided, the pulse-rate increased with a resulting low temperature and rapid pulse, a combination which invariably proved fatal. Treatment in these cases availed nothing. Digitalis, strychnine, whiskey, the ammonias were given but without effect, except for possible prolongation of life. Pneumococcic-serum was used in some cases, but did not prove effective.

The most serious complication other than broncho-pneumonia, and one of the saddest phases of the epidemic, was pregnancy in patients over five months and at full term, the larger number developed septic pneumonia and died quickly; others died of cardiac failure.

Prognosis in all cases of influenza was impossible. Today the patient was better, tomorrow

complications and death. The treatment was largely symptomatic, with prolonged rest in bed, good ventilation and proper nourishment. Stimulants such as whiskey in uncomplicated cases of influenza, when prescribed, apparently did not influence the disease, but when used indiscriminately and in large quantities, did much harm and in many instances caused death, by overstimulation and the after-depression resulting in complications.. Many patients got out of bed too early under the stimulant effect of whiskey and came down with pneumonia, which in nearly all cases proved fatal.

SUPERSTITION AND IGNORANCE IN PREVENTION AND TREATMENT.

Whiskey was among the sovereign remedies put forward both as a preventive and cure of the disease. Many persons, believing that an occasional drink of whiskey would keep the "flu" away, and used freely would cure the disease. As a rule whiskey was not prescribed by doctors, but in many instances it was a case of the laity taking the matter into their own hands. In many dry communities, large quantities of whiskey were brought in and in many of these communities disaster resulted, the larger death rate in these communities being ample evidence of the harmful effect of alcohol used ad libitum. Even in the cases of pneumonia, few, if any, doctors observed that whiskey was benefcial, and although used in a large majority of such cases, it did not alter the course of the disease. It is believed that doctors having had perhaps the greatest opportunity ever offered to test the efficacy of alcohol in this epidemic, will coincide in the opinion, that whiskey is without virtue in the treatment of the disease. Tobacco was believed by many to be a preventative, both smoking and chewing, but that this belief was not well founded, was made evident by the fact that a large number of persons who were chewers and smokers were attacked by the disease. Patent medicine and nostrum venders took advantage of the situation to prey upon the people with false claims and fradulent literature, setting forth the virtues of their various remedies. Asafetida—ancient and odoriferious—worn around the neck was used as a preventative. Many credulous persons believing in its potency as firmly as the Hindoo believes in his god. We concede the virtue of asafetida as a preventive in keeping off the "flu", only that the odor would keep away the crowd.

OVERCROWDING IN THE HOMES, AND BAD SANITATION.

Few persons, other than health officers and sanitary inspectors throughout the State, realized the overcrowding and bad sanitation that existed in the homes, especially in the rural districts and mining camps. Conditions found during the epidemic as to uncleanliness, bad sanitation and overcrowding were indescribable. In hundreds of places visited we found from three to six patients in one bed. In one home we found sixteen sick people all in one room in three beds, the doors closed tight, the windows down and even the shades pulled down. The air in the room was fetid, the odor horrible and one patient was actually choking for air. Four deaths occurred in this family. To find eight and ten patients all sick in one room was a common occurrence, spitting promiscuously on the floor, the bedding and clothing of the patients filthy beyond description and no ventilation. These places were veritable pest holes and doctors and nurses who entered these homes to give relief virtually took their lives into their own hands. Nature's great trio in the prevention and cure of disease, fresh air, sunshine, and soap and water, were relegated to the rear. These conditions of overcrowding and filth in the homes visited were not in the majority of cases due to poverty, but to false education as to proper standards of living, shiftless, lazy habits and a lack of ambition for clean, wholesome surroundings.

RELIEF WORK IN PRACTICAL FORM.

Many difficulties were confronted in giving relief, entire families being stricken at the same time, and not one able to provide food, or in many instances able to give water to the patients. It was found necessary in many communities to establish community kitchens where food was provided and distributed by house to house visitation, the work of distribution being done by community nurses under the auspices of the Red Cross. These community workers, in addition to the distribution of food, maintained in the homes as far as possible, proper ventilation, sanitation, took temperatures and reported conditions to doctors and Red Cross workers. In towns and camps emergency hospitals were rapidly established and in some instances entire families were moved into these hospitals.

SOME OF THE TRAGIC INCIDENTS.

In practically all sections there was a dread of the disease, among the people, which amounted almost to panic. Good neighbors who had never been found wanting before, in illness and distress,

resorted to the law of self preservation, and refused to visit their neighbors who were ill or dying. In some instances however, heroes and heroines were in evidence. Good men and good women, undeterred by fear of the disease, visited and provided for those who were helpless—good Samaritans in the fullest sense. The dead in some instances lay for hours without attention, it being sometimes difficult or impossible to get some good neighbor to lend a helping hand. In more than one instance, doctors were the only persons available to lay out and dress the dead, and frequently grief stricken relatives were placed in the heartrending situation of being forced to prepare their own loved ones for burial. At one place visited on a remote mountain, the mother was dead, the father dying and three small children crying for food. No one had visited this home for 48 hours. At another place visited, we found on top of an isolated mountain, a widow with five small children, all sick in one bed and no food in the house.

"THE SALT OF THE EARTH"—IN THE STRICKEN COMMUNITIES.

In each community visited we were much gratified to find a few public spirited citizens, men frequently of large business interests, who left their affairs and devoted untiring efforts to the work of caring for the sick and helpless. Red Cross workers, men and women, who through individual effort and through their local organization, fought the good fight and with their hearts in the work, did valiant service in every community. In every community visited, we found ministers of the gospel, in some instances with thermometers in their pockets, taking temperatures for the doctors, reporting conditions, carrying food and medicine to the patients, working as orderlies in the emergency hospitals and giving cheer and consolation to the stricken—religion in its most practical form.

DOCTORS AND NURSES.

True to its traditions, the medical profession, when called upon in all great crises, has "made good" in the present epidemic. Doctors at home and in the field have at great sacrifice of strength and in some instances life, rallied to the emergency. To those doctors, many of whom have not been actuated by financial consideration, but whose hearts have been in the work, and who have left their work at home and gone into the remote sections of the State to undergo hardship and danger, these need no greater reward for such services rendered than the consciousness of feeling that a duty to their fellows and for the sake of humanity, has been well-formed. In no less degree can we pay h o m a g e to those nurses—noble women—who under the auspices of the Red Cross, were sent into the stricken communities and who by their noble efforts gave relief to thousands of sufferers. The work of these women, many of whom lost their lives in the cause, was practical in the fullest sense of the word. In the emergency hospitals they served long hours, cheerful and willing workers at every beck and call. Some of the most practical and far reaching results was their work as community nurses, which consisted of house to house visitation, the distribution of food from the community kitchen, preparing nourishment at the homes, sometimes for the entire family, bathing the patients, furnishing clean clothing and bedding and maintaining, so far as possible, proper ventilation and sanitation in the home.

COUNTING THE COST.

The cost of the epidemic in Kentucky in dollars and cents can never be even approximated, but that in loss of time, medicine, funeral expenses and other necessary expenses, it will run into millions of dollars is without question. The greater and more vital cost in loss of lives will never be accurately known. Vital statistics records must necessarily be incomplete. In many instances in isolated sections rude coffins have been hastily made, and the remains buried without form or ceremony and without record. On the other hand, doctors have died without signing death certificates, and likewise undertakers have succumbed with their records incomplete. In some of the smaller mountain counties, the deaths recorded were one hundred and over, and in one county of only fifteen thousand population, nearly two hundred people died. Incomplete statistics to date conservatively estimate the loss of life in Kentucky to be from 4,000 to 6,000, and these figures for the reason given above are in all probability too conservative. Another phase of our liability from the epidemic is the large number of widows and orphans to be cared for by the county, state or nation. In many instances both the father and mother have lost their lives, leaving a large family of children unprovided for. In Pineville, in the emergency hospital, we had six children—made orphans by the disease—recovered and able to leave the hospital, but no place to send them. On a train from Hazard to Lexington we found four orphan children, the oldest a girl of twelve years and the youngest eighteen months, on their way from Perry County to Powell County, a journey of seventy-five miles, to their grandparents, whom we were reliably informed were not able to care for them.

Joseph Nathaniel McCormack, M.D.

(1847-1922)

DOCTOR McCormack was born in Nelson County, Kentucky on 9 November 1847. He received his medical education at the Miami Medical College in Cincinnati, from which he graduated in 1870. He practiced for a brief period in Nelson County, but in 1876 moved to Bowling Green, distinguishing himself during the yellow fever epidemic in Bowling Green and surrounding Warren County in 1878.

The State Board of Health was created by the Kentucky Legislature in 1879, and Doctor McCormack was appointed a member. Busily engaged in the promotion of public and professional interest in preventive medicine and public health, he served as President of the Kentucky State Medical Association in 1881. Through his efforts extending from 1883 until his death, laws were added to the Kentucky Statutes regarding public health, medical licensure and medical education. These statutes became models for other states.

Doctor McCormack travelled widely—both here and abroad—speaking in behalf of public health education and legislation. The following paper is one version of an address which he repeatedly made to various county, state and national medical societies in an effort to make the Health Departments at all levels of government, effective instruments in the eradication of preventable disease.

THE NEW GOSPEL OF HEALTH AND LONG LIFE*

By J. N. McCormack, M. D., of Kentucky.

The greatest asset of any nation, its most important resource to be considered, is that represented in its vigorous population, its children, women and men. In fact, farms, mines, forests, factories and similar things called wealth, have little more than an abstract value, except as there is such a population to operate and enjoy them. The drain upon this asset in this country from diseases now known to be preventable, and as a result of vicious and immoral living is estimated at more than one-third of the entire sick and death rate every year. The recognition of this drain and its causes, and a comparative study of the results of better sanitation in other countries, and in some sections of our own country, have so impressed economists, teachers and other leaders of thought, that the American Health League, a lay organization of 50,000 members, has been formed, with headquarters at Yale, to arouse and educate public sentiment on the subject.

These economists figure that there is an average of 1,500,000 deaths in this country every year, with 4,200,000 cases of sickness, affecting the comfort and happiness of 5,000,000 homes and 25,000,000 people. After careful study they tell us that over one-third of this enormous sick and death rate, a tax upon the people almost beyond calculation, can and should be prevented. As an argument for peace, it is shown that 210,000 men were killed in both armies during the five years of the civil war. As an argument for healthier living, it is shown that 750,000 persons have died from tuberculosis in the last five years and that about 1,000,000 are constantly sick of it. They show 250,000 deaths and 2,500,000 sick from typhoid fever in the same period, and a large sick and death rate from diphtheria, measles, scarlet fever and other diseases preventable with present knowledge, and urge that with proper governmental assistance, this life-saving knowledge should be constantly extended. It is then shown that in ten years our national government has expended $40,000,000, and now proposes to appropriate $250,000,000 more, to prevent tick fever in cattle, cholera in hogs and chickens, pests to crops and trees, and to protect other interests having money value, while in all its history it has never spent a dollar or lifted a hand to protect the people from these far more important domestic pestilences. There are experts and funds in abundance at Washington to go anywhere for investigation, or to prepare literature in regard to any animal or plant disease, any agricultural resource,

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water power, or other condition affecting commercial interests, but the citizen will inquire in vain for information about protecting his family from typhoid fever or other sickness.

Most of these facts are well known to medical men. They have long insisted that good health can and should be made more contagious than sickness, and, in direct conflict with their own interests, have urged the health reforms which would bring it all about, but in most states, and in the nation, have met almost constant indifference or antagonism from both legislative bodies and the people. This was in part because to the laity, medicine has always been an occult, mystic science, and still more because, until recent years, ours has been a discordant profession. This discord was in small part between the different systems of practice, but far more between physicians competing for the same practice, and was often fostered by their lay friends. The same thing existed in the clergy until recent years, dividing the religious world into hostile camps, and in all the other isolated vocations, lawyers alone living in the aggregate and escaping this curse.

A few years ago we were aroused to the enormity of this evil, to its baneful effects upon us and the people, we banded ourselves together for its extermination, probably never before did a reform so sweep a profession, and now, regardless of schools or pathies, ours is rapidly becoming one of the most harmonious of callings. This discord has existed so long, however, that it created a sentiment, a prejudice, if you will, against doctors, which is a habit of thought with most people, except as to their own physician, which did not disappear with the removal of the cause, and in spite of the rapid advances, of the professional, and the heroism and individual worth of its members, this is almost as strong as it was a generation ago. I speak in the light of an experience which has come to few men. I have been a State health official, and as such, represented my profession before my legislature for 30 years, and often before the Congress at Washington. Once or twice almost every day for six years I have spoken on this subject to popular audiences in every section of the Union, laymen discussing it freely at the close of my talks. In this way I have been able to make a study of doctors and what the people think of them in a very broad way, have found this sentiment almost universal, and it is on this account mainly, that it has been so difficult for us to secure and enforce our legislation.

You will first be shown how this feeling against doctors has affected us as a nation. For lack of authority for medical officers during our war with Spain, we lost 16 of our soldiers from preventable disease for every one dying as a result of battle, and 85 of each 100 were inmates of the hospitals. During the longer and more severe war in Manchuria, with full authority and rank for their doctors, Japan lost but one man from disease for every four killed in battle, and but 15 of 100 were in the hospitals. We had known of this danger to our armies, and had begged for proper authority for our army surgeons, for 25 years, and since these wars, with the object lessons of Cuba and Manchuria before the congress and country we are still begging, and practically the same dangers yet face our armies in the event of a foreign war. Facts of the same kind almost without number might be given to show that except in the emergency of epidemics, no other nation has been and still is so criminally negligent of the health and lives of both its soldiers and its citizens.

Bad as is this record for the nation, that for most states is little better. Probably at least one-third of those sick and of those taken to your cemeteries every year are afflicted with diseases which ought not to occur. About one of every ten deaths are from consumption, and in spite of all the talk about preventing it, you now have a large tubercular population. This is not an inherited disease, and if all the expectorated matter from every case now in the State could be collected and destroyed, as your health officials and physicians are earnestly trying to do, until all now sick of it either recover or die, and other necessary precautions be taken, you would soon have none but imported cases. You have a large sick and death rate in the State from typhoid fever every year. This is not only a preventable, but the most typical of the filth diseases. No one can have it except by getting into the mouth something from the bowels or kidneys of some one who has the disease, usually carried there by water, flies or milk. Medical literature abounds with accounts of fatal epidemics from all these sources in cities, towns, country districts and military camps. If these discharges from every case of typhoid fever could be systematically disinfected, clean water and milk provided, and flies gotten rid of, there would be no typhoid fever. There is also a large sick and death rate from diphtheria, dysentery, scarlet fever, measles, whooping cough and like diseases, to say nothing of the cruel slaughter of babies during every hot season from the use of dirty or adulterated milk. One and all, these diseases are a disgrace to our civilization. With clean, healthy living, personal and domestic, municipal and national, they could be so effaced as to have only historic interest. And it would actually cost less to do this than it does to treat and nurse the sick and bury the dead, to say nothing of the pain, sorrow and loss of life prevented.

When we have urged legislation for these pur-

poses, otherwise intelligent congressmen and state legislators have not hesitated to say that doctors asked for these laws for their own benefit without stopping to consider that in so far as they prevent sickness they diminish their own incomes, the very unselfishness of the movement causing it to be misjudged, as legislators saw no other vocation there working against its own interests. It was because ours is above all a humanitarian calling, charged with the duty of saving life, and in daily contact with the sorrow caused by sickness and death, that it took up this work, just as for the same reason it does more actual charity every day in every year than all other people and organizations put together. Again, all others may profit by their discoveries or inventions, but doctors cannot, their laws requiring that they be made public for the good of humanity. All of this has involved altruistic labor without parallel in human history, unappreciated and obstructed, largely because of the public sentiment fostered by the past discord in our ranks.

Had doctors been as united and taken the same pains to keep in touch with, and guide the people during the formative period of our government as the lawyers did, health and medical boards would always have been as much a part of the warp and woof of our county, state and national machinery as the courts. They ought to have been because more important, just in proportion as health and life are more important than property interests. Since this has been so insisted upon by political economists, an increasing number of our more thoughtful public men are coming to realize, as Gladstone, Disraelli, Bismark, Gambetta and other real statesmen in the older countries did long ago, that a health department at Washington, with laboratories and research workers in proportion to our power and wealth and the vast interests involved, as would investigate the causes of the common diseases not yet understood, to gather, tabulate and make public the facts in regard to every case of sickness and death which occurs in every county and state, with prevention as the only object, is as much a necessity, if our people are to have the benefactions of modern science utilized daily for the protection of their homes and families, as is the Supreme Court of the United States. This is done in other well-governed countries, as it is regardless of expense for domestic animals, crops, trees and similar interests with us, and the time has come for voters to quit sending men to Congress, legislatures, or other positions, who have not sense to appreciate the value of the health and lives of human beings.

For similar reasons a State Board of Health with ample funds and laboratories, and with members so compensated that they can give their full time to this life-saving work, is as important as the Appellate Court could possbily be. And, still more important, a board of health for each city and county, or for the two combined, with frequent inspections of schools, dairies, abattoirs, bakeries, groceries, factories, tenements, sewerage and garbage systems, and with laboratories to which any citizen may bring water, food, drugs, disease products, or anything else suspected as a danger to his family, for analysis without personal expense, is of as much practical importance as any court or other official agency could be. And it is not worth while to try to do these things without a health officer with special training and aptitude for his work, and such a salary that he can devote his entire time to it; for no man can be the kind of health officer here described and practice medicine. The positions are so incompatible that it would be just as reasonable to expect a lawyer to act as judge and support his family by the practice of law at the same time. It would be the best of investments to provide such comprehensive health systems everywhere, as substitutes for the political make-shifts so generally in vogue, because the greatest annual tax upon our people is not that paid into municipal, county, state and national treasuries, but the long unrecognized tax for preventable sickness and funerals.

With such aims and possibilities before it, fully realizing the magnitude of the reform, the obstacles, and the self-sacrificing labor required to carry it on, the American Medical Association with branches reaching into every State and county, and about 80,000 members, joining hands with all others, individual or organized, who will take part in it, has entered upon a broad campaign of education which it is hoped will ultimately reach every home in this land. In the very nature of it, medical men must lead this movement in most communities, and to better qualify them to do this, a carefully planned post-graduate course, adapted to the needs of all schools of practice, with weekly or more frequent meetings, and attractive rewards for those who complete the four years' work, has been placed within the reach of the profession of every county without cost. Thus, in time it is proposed that an up-to-date doctor will be placed within reach of every family now without one and at the same time leaders for this reform be developed or encouraged.

In addition to its scientific work it is proposed that each county society shall hold joint meetings with teachers' institutes, women's clubs, editors, lawyers, ministers, druggists, business, labor and other organizations, for discussion and instruction as to matters of mutual interest. Later, through teachers and others, the aim will be to reach every school child and family with practical information

as to the cause and prevention of sickness. In this plan, the physician is also to be a moral as well as a physical leaders of his people, setting an example of clean, healthy living in his own person and home, urging the same standard of morality for men and women, and securing the co-operation of teachers, ministers and druggists in warning the people, the young especially, of the dangers of immorality, habit-producing liquors and drugs, and all other things at enmity with pure living.

As will be readily seen, this reform involves just such a revolution in the practice of medicine as has gone on so rapidly in the practice of law in recent years. Lawyers were formerly engaged almost entirely in conducting litigation in the courts. Now, corporations and wise business men employ them almost exclusively to keep them out of the courts. So, it is only a question of time and popular intelligence when a large per cent of my profession will be acting mainly as medical advisers for families, to keep them well, instead of the more difficult and expensive task of treating them when sick. All sickness cannot be prevented with present knowledge, but most of the common diseases which are destructive to health and life in children and young people can, and with proper aid from governmental laboratory and research workers, this list should be constantly extended.

Do not get the idea that it will be easy to do all this, or that there is much real popular interest on the subject at present. The newspapers are the best exponents of public sentiment, and are most friendly to this movement, and so long as they give two or three pages a day to the races, foot and base ball and the brutalities of pugilism, and a fourth of a column a week to health news, we may be certain that there is little demand for the latter. The enlistment of political economists and teachers in the movement was the first real encouragement. The insertion of planks in the platforms of both political parties favoring a national health policy, and the campaign of education against tuberculosis, give promise of good if supported by systematic, wisely led lay organization in every section of the country, such as the American Health League is fostering.

Whether it will be necessary for physicians to go into public life in the interests of these reforms, as they were forced to do in Europe, is a question for the future. For a century our legislative bodies, state and national, were dominated by high class lawyers. Better opportunities are now open to this class and such positions are sought by a lower grade of lawyers and others, who make a business of politics. With this change, others have come. The problems before this country were never before so complex or difficult and, instead of being legal and for the lawyer, they are mainly economic, with social and moral elements, which require a higher official class for the solution. Broadly trained business and literary men, teachers and industrial leaders should certainly be selected in such numbers that their voices and votes would be effective. There is a doctor in close touch with almost every voter in this country and it may be better for them to assist in selecting men of the kind indicated than to go into public life themselves.

In any event it is an educational work, and our profession has the knowledge which fits and imposes the duty of leadership. It will involve years of unselfish labor, and all may not be equal to it. How doctors are to be compensated under this new order and whether as many will be needed, we have not stopped to inquire. We know that it opens a new field of unlimited possibilities, that the doctor of the future will be a far more important and useful man than the one of today, and we only ask for such a league with the people, offensive and defensive, as will insure success in every community.

Edgar Erskine Hume, Major General, M.C., U.S.A. [1889-1952]

DOCTOR Hume, one of Kentucky's most distinguished physicians, was born 26 December 1889 in Frankfort, Kentucky, the son of Doctor E. E. and Mary (Smith) Hume. He attended Center College and received his Master's degree there in 1909. He received his M.D. degree from The Johns Hopkins University School of Medicine in 1913. Postgraduate studies were pursued in Munich and Rome and later (1917), he was an honor graduate of the Army Medical School.

He received many citations and honors for his field work in Italy, France and Serbia during and after World War I. During World War II, he distinguished himself in North Africa and Italy both as a physician and an administrative officer. He was Chief of the Allied Military Government of the Fifth Army in the Mediterranean Theater. During the Korean "Incident", he was Chief Surgeon of the Far East Command and Surgeon to the United Nations Command in Korea. He retired on 1 January 1952 and died suddenly on 24 January 1952, of a dissecting aneurysm of the aorta.[1]

From 1922-1926, he was the editor of the Surgeon General's *Index Catalogue,* and from 1932-1936, Librarian of the Surgeon General's Library. It was during these years that he was able to make numerous valuable additions to our medical literature. The following paper originally appeared in Annals of Medical History N. S., *8* (July) 1936, and was reprinted in the August 1936 issue of the Kentucky Medical Journal. Some errors of fact appear in this appraisal in light of our present knowledge, but some discrepencies are bound to occur if one does not have access to primary source materials, such as Board of Trustee minutes, etc., when one compiles such a detailed account as this. Despite an occasional incorrect date or an omission of a name or title in the text, I believe it is fitting to reprint this paper again for it is one of the most complete appraisals of the early medical literature of Kentucky that is currently available.

[1] *Emmet Field Horine, "Special Article: Edgar Erskine Hume, Major General, M.C., U.S.A. (1889-1952)", J. Ky. State Med. Assoc. 50, pp. 212-13 (May) 1952.*

EARLY KENTUCKY MEDICAL LITERATURE*

Major Edgar Erskine Hume, M.C., U.S.A.
Librarian of the Army Medical Library
Washington, D. C.

Not the least valuable collection in the Army Medical Library is that pertaining to the publications of those distinguished medical men who, by their genius and perseverence, established for early Kentucky a reputation as a center of medical learning comparable to that of the best in the country. Their story has often been told, but the usual biographies do not include data as to their writings that have come down to us. The six Kentucky medical schools have happily consolidated into one institution of first rank, which carries on the ideals of its six forebears. These schools have sponsored a succession of medical journals that have held their own with those of other states and in some cases with those of the rest of the world. As far as I have been able to learn there has never been compiled heretofore a list of these periodicals, the number of which will certainly surprise the average reader. The Army Medical Library contains practically complete files of all these journals, many of which are to be found in no other place. There is also a reasonably complete file of catalogues and annual circulars of Kentucky schools.

Medical Schools of Kentucky

Transylvania University (Lexington) (Medical Department).

Founded 1799. Closed 1857. During this period there were 6456 students, and 1881 graduates.

Louisville Medical Institute.

* Reprinted from *Ky. Med. Jour.*, No. 8, Vol. 34, August 1936, pp. 349-366.

Founded 1837. After 1845, by State charter, known as the School of Medicine of the University of Louisville.

Kentucky School of Medicine (Louisville). Founded 1850. Consolidated with the University of Louisville 1908.

Louisville Medical College. Founded 1869. Consolidated with the University of Louisville 1908.

Hospital College of Medicine (Louisville). Founded 1873. Consolidated with the University of Louisville 1908.

Medical Department of Kentucky University (Louisville). Founded 1898. Consolidated with the University of Louisville, 1907.

The contributions by early Kentuckians to the sum of medical knowledge is appreciated on reference to their preserved writings, the largest collection of which is in the Library of which I have the honor to be director.

The most famous of these men was, of course, McDowell. Most of the others whose fame and skill threw light on our medical profession at the end of the eighteenth and first part of the nineteenth centuries, were teachers at Transylvania University or that of Louisville, or both. I shall mention some of them, noting how richly their writings are represented in the Army Medical Library. Lack of space prevents listing all whose worth would otherwise merit it.

Ephraim McDowell, the Father of Ovariotomy, and His Publications

Sharing with Henry Clay the honor of representing Kentucky in the Hall of Fame in the National Capitol in Washington, is Ephraim McDowell (1771-1830). There is no need to tell of his great contribution to surgery for his name is well known even to the laity. In 1879 Dr. Gross said that McDowell had, in the seventy years that had passed since his famous operation, "added upward of 40,000 years to woman's life," ovariotomy having "rescued more than 2,000 women from an untimely Grave." Educated at the University of Edinburg, where he was also the pupil of John Bell, the celebrated private teacher, he returned to America in 1795 and settled in Danville. He trained many young physicians in his office, always cautioning them against the too free use of medicines. He was anything but a prolific writer. Though he performed his famous ovariotomy in Danville in 1809, and his success became widely known throughout the state, he waited until 1816 before publishing an account of it. In the meantime he had twice repeated the operation. He sent a copy of his paper to Bell in Edinburgh, but it was never received, as Bell was traveling on the Continent and never returned to Scotland. Another copy, fortunately, was published in the *Eclectic Repertory and Analytical Review* of Philadelphia for October 1816 under the title "Three cases of Extirpation of Diseased Ovaria," a paper which, as Robinson says, conferred immortality on this journal. In the same journal for October 1819, McDowell reported three more cases under the title "Observations on Diseased Ovaria." And that is all we have from the hand which held the scalpel far more skillfully than the pen. But there is much in the Army Medical Library by other hands about the work of this Titan, called the "Father of Abdominal Surgery." Dr. McMurtry forcibly expressed it: "Pelvic and abdominal surgery began with ovariotomy; ovariotomy began with McDowell." He was, moreover, a skillful lithotomist, one of his patients having been James Knox Polk, later President of the United States.

ORIGINAL PAPERS.

Three Cases of Extirpation of diseased Ovaria.

By EPHRAIM McDOWELL, M.D. of Danville, Kentucky.

In December 1809, I was called to see a Mrs. Crawford, who had for several months thought herself pregnant. She was affected with pains similar to labour pains, from which she could find no relief. So strong was the presumption of her being in the last stage of pregnancy, that two physicians, who were consulted on her case, requested my aid in delivering her. The abdomen was considerably enlarged, and had the appearance of pregnancy, though the inclination of the tumor was to one side, admitting of an easy removal to the other. Upon examination, per vaginam, I found nothing in the uterus; which induced the conclusion that it must be an enlarged ovarium. Having never seen so large a substance extracted, nor heard of an attempt, or success attending any operation, such as this required, I gave to the unhappy woman information of her dangerous situation. She appeared willing to undergo an experiment, which I promised to perform if she would come to Danville, (the town where I live) a distance of sixty miles from her place of residence. This appeared almost impracticable by any, even the most favourable conveyance, though she performed the journey in a few days on horseback. With the assistance of my nephew and colleague, James McDowell, M.D., I commenced the operation, which was concluded as follows: Having placed her on a table of the ordinary height, on her back, and removed all her dressing which might in any way impede the operation, I made an incision about three inches from the musculus rectus abdominis, on the left side, continuing the same nine inches in length, parallel with the fibres of the above named muscle, extending

Fig. 1. First Page of Dr. Ephraim McDowell's Account of the First Ovariotomy. This Epoch-Making Operation was Performed at Danville, Kentucky, in 1809, but the First Account of it was not Published until Seven Years Later, in the Eclectic Repertory and Analytical Review of Philadelphia, 1816. The Report is but Three Pages in Length.

John Lizars, who had charge of Bell's affairs in Edinburgh, during the preceptor's absence on the Continent, and who had received McDowell's letter and report of his operation, held the precious manuscript for eight years and finally referred to it in his article: "On Extirpation of the Ovaria, with Cases," which he published in the *Edinburgh Medical and Surgical Journal* for October 1824. In this paper he cleverly attempted to

make it appear that his own original work had given the world the surgical triumph! Lizar's paper is interesting reading alongside of McDowell's and in the light of modern knowledge. All three may be seen in the Army Medical Library. Mcowell's biography by his granddaughter, Mary Young Ridenbaugh (1890), and Dr. August Schachner's excellent monograph on McDowell's life and work (1924), give a good picture of this stout-hearted old surgical pioneer.

Well do I remember the monument to McDowell in Danville. As a student for five years at Centre College, of which McDowell was one of the first trustees, I used to pass it daily, with classmates likewise aspiring to the medical profession. We were inspired by this silent tribute to his greatness, erected in 1879 by the Kentucky Medical Association, and at the dedication of which Prof. Gross and others spoke, and letters were read from many celebrated physicians, including such men as Oliver Wendell Holmes. A volume of these addresses and letters is in the Army Medical Library.

Transylvania University

In 1870 the State of Virginia placed 8,000 acres of land in the hands of thirteen trustees "for the purpose of a public school or seminary of learning," that they "might at a future day be a valuable fund for the maintenance and education of youth." Twelve thousand acres more were added in 1783 and the name Transylvania Seminary given the new institution. From these simple beginnings there developed an institution of great renown. The name Transylvania University was adopted under the Act of the Kentucky Legislature. Early in 1799, at the first meeting of the trustees of the new university, they instituted "The Medical Department or College of Transylvania," which was soon to become prosperous and celebrated. The account of this efficient medical school is given at length in Dr. Robert Peter's monograph (1905), Filson Club Publication No. 20.

The first medical professors at Transylvania were Drs. Brown and Ridgely. Others followed soon thereafter. It is of interest to give the entire roll, not a long one, of the faculty of this fine old institution, for it shows the type of men who first taught medicine in Kentucky.

Medical Professors at Transylvania University

Surgery

Samuel Brown, 1799-1809
Benjamin Winslow Dudley, 1809-1850.
Ethelbert Ludlow Dudley, 1851-1857.

Anatomy

Samuel Brown, 1799-1809
Benjamin Winslow Dudley, 1809-1843
James Mills Bush, 1844-1857

Theory and Practice of Medicine

Frederick Ridgely, 1799-1805
James Fishback, 1805-1809
James Overton, 1809-1818
Samuel Brown, 1819-1824
Daniel Drake, 1825-1827
John Esten Cooke, 1827-1837
John Eberle, 1837
Nathan Ryno Smith, 1838-1840
Elisha Bartlett, 1841-1843, 1846-1848
Lotan G. Watson, 1844-1845.
Samuel Annan, 1849-1853
William Stout Chipley, 1854-1857

Institutes, Physiology, etc.

Joseph Buchanan, 1809-1818
Charles Caldwell, 1819-1836
James Conquest Cross, 1837-1842
Leonidas M. Lawson, 1843-1846
Ethelbert Ludlow Dudley, 1847-1850
Henry Martyn Skillman, 1851-1857

Obstetrics, etc.

Frederick Ridgely, 1799
William Hall Richardson, 1815-1844
Thomas Duche Mitchell, 1845
Samuel Annan, 1846-1848
William M. Boling, 1849
Samuel M. Letcher, 1851-1857

Materia Medica, Botany, etc.

Daniel Drake, 1817, 1823-1824
Charles Caldwell, 1819-1822
Charles Wilkins Short, 1826-1837
Thomas Duche Mitchell, 1838-1848
Henry Massie Bullitt, 1849-1850
John Rowan Allen, 1851-1855
Alexander Keith Marshall, 1856
Benjamin P. Drake, 1857

Chemistry and Pharmacy

Samuel Brown, 1799
James Blythe, 1815-1825
Lunsford Pitts Yandell, 1831-1836
Thomas Duche Mitchell, 1837
Robert Peter, 1838-1857

The Translvania Medical Library

The Army Medical Library, as the national medical library of our country, regards with affection one of its elder sisters, the famous Medical Library of Transylvania University in Lexington. Not for nothing has the medical profession of Kentucky been proud for nearly a century and a half of this splendid old collection. It has played an important role in medical education and, though no longer collecting medical books, remains a rich repository

of medical gems that shine today no less brilliantly than when placed on the shelves by loving hands long ago. It was the first notable medical library west of the Alleghenies and as a Kentuckian and an honorary Transylvanian, I am often able to tell of it with pride, to visitors to the Army Medical Library in Washington.

THE

TRANSYLVANIA JOURNAL

OF

MEDICINE

AND THE ASSOCIATE SCIENCES.

EDITED BY
JOHN ESTEN COOKE, M. D.
Professor of the Theory and Practice of Medicine in Transylvania University,
AND
CHARLES WILKINS SHORT, M. D.
Professor of Materia Medica and Medical Botany in the same Institution.

VOL. I.

LEXINGTON, KENTUCKY.
PRINTED QUARTERLY, BY JOSEPH G. NORWOOD.
1828.

Fig. 2. Title Page of First Volume of The Transylvania Journal of Medicine, 1828, the First Medical Journal Published in Kentucky and One of the Most Famous American Serials of the First Part of the Nineteenth Century.

It is almost as old as the fine old University that established it, for we read that at a meeting of the Board of Transylvania Seminary in 1784 they acknowledged the gift of the Rev. John Todd of Louisa, in Virginia, of "a Library and Philosophical Apparatus for the encouragement of Science in this institution." And it grew vigorously. Dr. Samuel Brown, the first medical professor of Transylvania, was given $500 by the Trustees to buy books, though money was far from plentiful in the Western country, as it was then called. In 1820 Dr. Caldwell, Professor of Medicine, procured the sum of $13,000 from the Kentucky Legislature and the city of Lexington, with which to purchase books in Paris. In Caldwell's famous autobiography, to which I shall refer again, we find the following passage regarding his acquisition of medical books in the French capital:

"The time of my arrival in Paris was uncommonly and unexpectedly propitious for my purpose. The ravagings and wastelayings of the French Revolution had not entirely passed away. Toward the close of that catastrophe the libraries of many wealthy and literary persons had found their way to the shelves of the bookseller. No sooner was I apprised of these precious repositories than I procured permission to ascertain of what they consisted. Some of them were stored with valuable literature. . . . . I found and purchased at reduced prices no inconsiderable number of the choicest works of the fathers of medicine from Hippocrates to the revival of letters. Works which in no other way, and perhaps at no other time, could have been collected so readily and certainly on terms so favorable, in either Paris or any other city in the world. Hence the marked and decided superiority of the Lexington Medical Library, in those works, to any other in the West and South, and probably in the whole United States—not excepting that of Philadelphia, the parent school of medicine in the Union." (pages 391-2)

The doctor also mentioned help given him in his work of collecting these books, by the Marquis de LaFayette and his son, George Washington de LaFayette. Caldwell was professor at Transylvania when LaFayette visited Lexington in 1825 and received the honorary degree of Doctor of Laws at the University.

In 1839 Drs. Peter and Bush, of the Transylvania faculty, spent $11,000 in London and Paris for books and apparatus for the institution. Rafinesque was one of the early librarians, which accounts for the richness of the Transylvania collection in botanical works (see Mrs. Norton's excellent account of the Library in the Transylvania College Bulletin for 1919).

The Transylvania Library contains a number of books missing from the shelves of the Army Medical Library. For example, the Patavii edition (1666) of the "Opera Chirurgica" of Hieronymus Fabricius, the teacher of Harvey, and famous in his own right for his studies on ligations and the valves of the veins. Like this of ours, the Transylvania Library has many of the earliest American medical periodicals, edited by such men as Robley Dunglison, Edward Miller, and David Hosack. Volume one of the Transylvania set of the *American Medical and Philosophical Register,* 1814 contains Hosack's inscription "For the Library of

Transylvania Univ. from D. Hosack." Complete sets of the *Transylvania Journal of Medicine and the Associated Sciences* are very rare, the Union List of Serials listing only three sets other than those in the Transylvania and Army Medical Libraries.

Chronological List of Medical Journals Published in Kentucky

The following list of the medical journals published in Kentucky from the earliest (1828) to those still in existence, has been compiled from the files of the Army Medical Library. In no other place could this have been done, and for the first time one can announce that in all there have been fifty-one medical journals published in Kentucky! Here they are in chronological order:

1. *The Transylvania Journal of Medicine and the Associate Sciences* (Lexington). The first medical journal published in Kentucky. Quarterly. Edited by John Esten Cooke and Charles Wilkins Short. Volumes 1 to 12, February 1828 to March 1839. The last issue was that for "Jan.-Feb.-March, 1839, No. 1, Volume 12." Volumes 5 to 9 edited by L. P. Yandell; volume 10 by Robert Peter; volume 11 by the Medical Faculty of Transylvania University; volume 12 by T. D. Mitchell. Volumes 9 to 12 also known as volumes 1 to 3 of the new series.

2. *The Western Journal of Medicine and Physical Sciences* was edited by Daniel Drake in Cincinnati, beginning 1827, being the continuation of *The Western Quarterly Reporter of Medical, Surgical and Natural Sciences* (1822-1823), the first medical journal published west of the Alleghenies. It has become the rarest American medical journal. While not published in Kentucky, it is included in this list for interest on account of its intimate connection with Kentucky publications and because of Drake's connection with the medical schools of the State. It contains numerous contributions by other Kentucky physicians. It was in 1840 consolidated with *The Louisville Journal of Medicine and Surgery* to form *The Western Journal of Medicine and Surgery.*

3. *The North American Medical and Surgical Journal* (Philadelphia) though not published in Kentucky is likewise included in this list because it was published by the *Kappa Lambda Society of Aesculapius,* which was founded by Dr. Brown and others at Transylvania University in 1819. The journal was established in 1826 and continued to 1831, five volumes.

4. *The Medical Friend of the People* (Harrodsburg). Monthly. Published by Anthony Hunn. Only volume 1, numbers 1 to 15, 1829-1830, is known. The Army Medical Library has only number 7 of volume 1, September, 1829.

5. *The Louisville Journal of Medicine and Surgery.* Quarterly. Edited by Lunsford P. Yandell, Henry Miller, and Theodore S. Bell. Only two numbers were published, 1 and 2 of volume 1, January to April 1838. In January 1840 it was revived and consolidated with *The Western Journal of the Medical and Physical Sciences,* forming *The Western Journal of Medicine and Surgery.*

THE

WESTERN

QUARTERLY REPORTER

OF

MEDICAL, SURGICAL,

AND

NATURAL SCIENCE.

SUPPORTED BY PHYSICIANS AND NATURALISTS OF THE WESTERN COUNTRY.

EDITED BY

JOHN D. GODMAN, M. D.

Member of the Academy of Medicine of Philadelphia, Honorary Member of the Medical Society of Maryland, Honorary Member of the Baltimore Medical Society, Member of the Academy of Natural Sciences, Philadelphia, late Professor of Physiology to the Philadelphia Museum, Honorary Member of the Cincinnati Medical Society and of the Lexington Medical Society, &c.

VOLUME I.

CINCINNATI:

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1822.

Fig. 3. Title Page of First Volume of The Western Quarterly Reporter of Medical, Surgical and Natural Sciences, Cincinnati, 1822. This is the Rarest American Medical Journal. Many of its Early Contributors Were Professors at Transylvania University, Lexington, Ky.

6. *The Western Journal of Medicine and Surgery* (Louisville). Monthly, two volumes annually, Edited by Daniel Drake and Lunsford P. Yandell. Begun in January 1840, volume 8 completed in December 1843; Second Series, volumes 1 to 8, January 1844 to December 1847; Third Series,

volumes 1 to 12, January 1848 to December 1853; New Series (i. e., Fourth), volumes 1 to 4, January 1854 to December 1855. It was continued in May 1856 by Drs. Gross and Richardson as *The Louisville Review.* Volume 5 had Thomas W. Colescott added to staff; volumes 1 to 4, New Series, Yandell was sole editor. This journal was a continuation of *The Western Journal of the Medical and Physical Science,* united with *The Louisville Journal of Medicine and Surgery.*

7. *The Western and Southern Medical Recorder* (Lexington). Edited by James Conquest Cross. Monthly. Volume 1 began in November 1841 and ended in October 1842. Numbers 1 to 4 of volume 2 were from January to April, 1843. In May 1843 it was merged with *The Western Lancet.*

8. *Journal of the Proceedings of a Convention of the Physicians of Kentucky.* Held in Frankfort on January 11, 1841. Published at Frankfort.

9. *Proceedings of the Physiological Temperance Society of the Medical Institute of Louisville.* Louisville, 1842.

10. *The Western Lancet* (Cincinnati, and later Lexington). Monthly. Devoted to medical and surgical science. Edited by Leonidas M. Lawson. Volumes 1 to 8 from May 1842 to December 1857, Cincinnati. Volumes 5 to 6, bimonthly, with title on cover *The Western Lancet and Medical Library.* Volumes 7 to 10, two volumes annually. Volumes 4 to 5 published at Lexington. In volume 5 the words "Devoted to medical and surgical science" were dropped from the title-page. With volume 7 the words *"and Hospital Reporter"* were added to the title. With volume 14 the words *"and Hospital Reporter"* were dropped and *"a monthly journal of practical medicine and surgery"* added. With volume 10 Harrison was dropped; with volume 11 George Mendenhall added; with volume 14 Mendenhall dropped and T. Wood added; with volume 16 Lawson dropped; with volume 17 G. C. Blackman added; with volume 18 Wood dropped. Volume 6 was completed in 8 numbers, May to December 1847. Volume 7 commenced in January 1848. In May 1843 *The Western and Southern Medical Recorder* merged with this journal. In January 1858 it was united with *The Cincinnati Medical Observer,* forming *The Cincinnati Lancet and Observer.*

11. *The Transylvania Medical Journal* (Lexington). Edited by Ethelbert L. Dudley, under the supervision of the Transylvania Faculty of Medicine. Bimonthly. Volumes 1 to 2, June 1849 to June 1851; New Series, volumes 1 to 2, August 1, 1851 to August 1853. Published at Louisville 1850-1853. Volume 1, New Series, was semimonthly; volumes 2-3, monthly. Volume 2, First Series, edited by Dudley under the supervision of the faculties of the Kentucky School of Medicine and the Transylvania University. No. 2, volume 2, H. M. Bullitt added as editor; no. 1, volume 1, New Series, B. I. Raphael added; volume 2, New Series, by L. J. Frazee. Continued after September 1853 as *The Kentucky Medical Recorder.*

12. *Transactions of the Kentucky State Medical Society.* Founded 1851. Published at several places and under various names as follows: *Transactions of the Kentucky Medical Society* for the 1st year (Frankfort, 1851), the 2nd year (Louisville, 1852); none published for 1853, 1854 or 1855; 5th year (Louisville, 1856); meetings said to have been held irregularly 1859 to 1867 but no minutes have been preserved; in 1868 (at Cincinnati) there were published *Proceedings of the Meeting for Reorganization of the Kentucky Medical Society,* 1867, 13th annual meeting. Proceedings of the 14th annual meeting (Louisville, 1869). With the fifteenth annual meeting, 1870, the name *Transactions, etc.,* was resumed. The *Transactions* of the 15th annual meeting 1870 to those for the 20th annual meeting were published at Louisville, 1870 to 1875. The *Transactions* of the 21st annual meeting were published at Paducah, 1876. Those for the 22nd and 23rd annual meetings were published at Louisville, 1877 and 1878. In 1879 the name of the publication was changed to *Minutes of the Kentucky State Medical Society,* those for the 24th and 25th annual meetings being published at Louisville, 1879, 1880. Those for 1881 to 1883 were probably published but no copy is in the Army Medical Library. With the 29th annual meeting, 1884, the name *Proceedings,* etc. was resumed and they were published at Louisville, 1885. The *Proceedings* are more or less complete, while the Minutes contain only the President's annual address and business matters. R. R. Bowker in "Publications of Societies," 1899, says: "Publication of the annual volumes of transactions was discontinued again in 1879 until 1890 during which time the reports and papers of the Society were published in the medical press of the state." From 1886 to 1891 there appeared: *Minutes of the Annual Sessions of the Kentucky State Medical Society,* 30th to 36th annual sessions, Louisville, 1886-91. In 1892 a new series was begun, called: *Transactions of the Kentucky State Medical Society, New Series,* Volumes 1 to 8 (37th to 42nd, and 44th to 45th annual meetings), 1892-1900. No volume was issued for the 43rd annual session, 1898 (as stated by Secretary in the 1899 volume). The Army Medical Library has no copy of the Transactions for 1901 or 1902 but those for 1902, at least, were published. In 1903 there began a new publication: *Bulletin of the Kentucky State Medical Association.* This was

published in 1903 and 1904 and thereafter continued as the *Kentucky Medical Journal* (which see).

13. Proceedings of the Kentucky State *Medical Society. See Transactions of the Kentucky State Medical Society.*

14. *Minutes of the Kentucky State Medical Society. See Transactions of the Kentucky State Medical Society.*

15. *The Kentucky Medical Recorder* (Louisville). A Continuation of *The Transylvania Medical Journal;* began with volume 3, No. 1, for September 1853 and continued to No. 10 for June 1854. (Three volumes.) Edited by Henry M. Bullitt and Robert J. Breckinridge.

16. *The Louisville Review.* A bi-monthly journal of practical medicine and surgery. Edited by Samuel D. Gross and Tobias G. Richardson. Volume 1 of four numbers appeared from May to November, 1856. It was a continuation of *The Western Journal of Medicine and Surgery.* In September, 1856, Drs. Gross and Richardson accepted appointments in medical schools in Philadelphia, and the *Review* was published in Philadelphia in November, 1856. In January 1857 it united with *The Medical Examiner* (Philadelphia), forming *The North American Medico-Chirurgical Review,* which continued until 1861.

17. *The Louisville Medical Gazette* Semimonthly. Edited by L. J. Frazee. Only numbers 1 to 7 of volume 1, January 1 to April 1859, were published.

18. *Semi-Monthly Medical News* (Louisville). Edited by Samuel M. Bemiss and J. W. Benson. One volume appeared, running from January 1 to December 15, 1859. It was thereafter continued as *The Monthly Medical News.*

19. *The Monthly Medical News* (Louisville). Edited by S. M. Bemiss and J. W. Benson. Two volumes annually, being the continuation of *Semi-Monthly Medical News,* the first of which was Volume 2, 1859. Ended with Volume 3, 1860. Dr. Benson was sole editor of Volume 3. Title on covers *The Louisville Monthly Medical News.*

20. *The Louisville Medical Journal* Monthly. Edited by Thomas W. Colescott. Only one volume issued, Numbers 1 to 6, February to July, 1960.

21. *The Sanitary Reporter* (Louisville). Published by the United States Sanitary Commission. Semi-monthly. Two volumes published, May 15, 1863 to December 15, 1864. Also a supplementary closing number dated August 15, 1865.

22. *The Richmond and Louisville Medical Journal* (Louisville). E. S. Gaillard, editor and proprietor. Monthly, two volumes annually. The title of Volumes 1 to 4 and Number 1 of Volume 5 was *The Richmond Medical Journal* (Richmond, Virginia). Beginning with Number 6 of Volume 5 and continuing to Volume 28, Number 4, this journal continued from June 1868 to October 1879. In November 1879 the journal was removed to New York City with Number 5 of Volume 28 and the title changed to *Gaillard's Medical Journal.* In January 1883, *The American Medical Weekly* was merged with this journal and it became a weekly. With Volume 36, 1883 it again became a monthly. Dr. Gaillard died on February 2, 1885 and the publication was continued by M. E. Gaillard. After Dr. Gaillard's death, Dr. Peter Brynberg Porter became editor and continued until 1887 (Volume 39 to No. 4 of Volume 44, 1885-1887). George Tucker Harrison was editor with a number of associates from November 1887 to 1902 (Number 5 of Volume 44 to Volume 77). H. S. Baketel was editor in 1904 and probably in 1903, although no editor's name is given. William Edwards Fitch became editor in 1905 and continued until the end of the journal in 1911 (Volumes 82 to 93). During his editorship the name became *Gaillard's Southern Magazine* and the place of publication was Savannah, Georgia (Volumes 83 to 93, 1906 to 1911).

23. *The Physiologist* (Louisville). A popular domestic journal designed to explain and illustrate the laws of physical culture, etc. By C. W. Gleason and A. O'Leary. One issue, November 1, 1869 (an advertisement).

24. *The American Practitioner* (Louisville). Formerly *The Western Journal of Medicine.* A monthly journal of medicine and surgery. Edited by David W. Yandell and Theophilus Parvin. Two volumes annually. Volumes 1 to 32 were published from January 1870 to December 1885. A continuation of *The Western Journal of Medicine.* In July 1883, Volume 28, John A. Octerlony became co-editor in place of Dr. Parvin. In Volume 30 and later, Dr. Yandell was the sole editor. In January 1886 the journal united with *The Louisville Medical News,* forming *The American Practitioner and News.*

25. *The American Medical Weekly* (Louisville. Edwin Samuel Gaillard, editor and proprietor. Two volumes annually. Continued from Volume 1, Number 1, July 4, 1874 to Volume 16, Number 3, January 20, 1883. After October 11, 1879 it was suspended until January 1, 1881. Volumes 6 to 13, 1877-1881, were published fortnightly, with the title *The American Medical Bi-Weekly.* After January 20, 1833 it was merged in *Gaillard's Medical Journal.*

26. *The Louisville Medical Reporter* (Henderson). A weekly journal. Edited by J. L. Cook; Associate Editor, James M. Holloway. Only one issue published, August 6, 1874, at Henderson.

27. *Transactions of the McDowell Medical So-*

ciety for the Year Ending November 4, 1874. Held at Henderson, Kentucky, May 7, 1874 and at Madisonville, Kentucky, November 4, 1874. Published at Evansville, Indiana, 1875.

28. *Transactions of the Transylvania Medical Association* (n.p.). Held at Shelbyville, Kentucky, November 3, 1875. One issue only.

29. *The American Medical Bi-Weekly* (Louisville). See *The American Medical Weekly,* above.

30. *The Louisville Medical News.* A weekly journal of medicine and surgery. Edited by Richard O. Cowling and William H. Galt. Two volumes annually. Twenty volumes issued from 1876 to 1885. In Volume 5, 1878, Lunsford P. Yandell became co-editor in place of Dr. Galt. Volume II edited by Dr. Cowling and H. A. Cottell (Dr. Cowling died April 2, 1881). Volumes 12-13 edited by Dr. Cowling and J. W. Holland; Volume 14 edited by L. P. Yandell and L. S. McMurtry; Volumes 15-17 edited by Drs. Yandell and Cottell (Dr. Yandell died March 12, 1884); Volume 18 edited by Dr. Cottell alone; Volume 19 had J. Morrison Ray added as co-editor. In January 1886 the journal was united with *The American Practitioner,* forming *The American Practitioner and News.*

31. *The Medical Herald* (Louisville). A monthly journal of medicine and surgery. Edited by Dudley S. Reynolds and Joseph M. Mathews. Volumes 1 to 11, May, 1879 to 1889. In Volumes 2 to 6 Dr. Reynolds was sole editor. In Volume 7, Edward Miller and M. F. Coomes became editors. Continued after 1889 as *The New Albany Medical Herald* of New Albany, Indiana.

32. *Proceedings, Addresses and Discussions of the Third Semi-Annual Meeting of the Kentucky State Sanitary Council* (Louisville). Held at Bardstown, Kentucky, March 26 and 27, 1884.

33. *The American Practitioner and News.* Biweekly journal of medicine and surgery (Louisville). David W. Yandell and H. A. Cottell, editors. Two volumes annually. Volumes 1 to 45 and Numbers 1 and 2 of Volume 46, from 1886 to 1912 appeared. The journal was formed by the union of *The American Practitioner* with *The Louisville Medical News.* In 1912 is united with *The New England Medical Monthly* to form *American Practitioner.*

34. *Progress.* A monthly magazine for students and practitioners of medicine (Louisville). Edited by Dudley S. Reynolds. Volumes 1 to 3 from 1886 to 1889. With Volume 4 it became *The Medical Progress.* A monthly magazine for students and practitioners of medicine.

35. *The Southwestern Medical Gazette.* A monthly journal of medicine and surgery (Louisville). Edited by M. F. Coomes and J. B. Marvin. Two volumes appeared, 1887-1888.

36. *Proceedings, Addresses and Discussions of a Public Health Conference Held at Lousiville, Kentucky, May* 24 *and* 25, 1887, under the auspices of the State Board of Health. Published at Frankfort, Kentucky, 1887.

37. *The Medical Investigator.* An independent journal devoted to medicine and temperance (Louisville). Monthly. S. F. Smith, editor and publisher. Numbers 1 to 5 of Volume 1 appeared from April 1888 to February 1889.

38. *The Medical Progress.* A monthly magazine for students and practitioners of medicine (Louisville). Edited by Dudley S. Reynolds, J. F. Barbour, *et al.* A continuation of *Progress.* Began with Volume 4, 1890 and ceased publication with the January issue of 1930, Volume 46. Two volumes were published in 1890. In 1891 Robert C. Kenner became editor. From 1898 to 1930 J. S. Moreman was editor.

39. *Louisville Medical Monthly.* Devoted to medicine and surgery. James B. Steedman and George M. Warner, editors. Volumes 1 to 6, March 1894 to July 1899. In August 1899 it united with The Louisville *Journal of Surgery and Medicine,* forming *The Louisville Monthly Journal of Medicine and Surgery.*

40. *Mathews' Medical Quarterly.* A journal devoted to the diseases of the rectum, gastrointestinal disease, and rectal and gastrointestinal surgery (Louisville). Joseph M. Mathews, editor and proprietor, Henry E. Tuley, associate editor and manager. Volumes 1 to 3 from 1894 to 1896. In 1897 it was continued under the title: *Mathews' Quarterly Journal of Rectal and Gastro-Intestinal Diseases.*

41. *Kenner's Journal of Health.* A monthly magazine devoted to the attainment and preservation of health and interests of home. Edited by Robert C. Kenner. Only Numbers 1 to 5 of Volume 1 appeared, December 1895 to April 1896.

42. *Mathews' Quarterly Journal of Rectal and Gastro-Intestinal Diseases* (Louisville). Editors: Joseph M. Mathews and Henry E. Tuley. A continuation of *Mathews' Medical Quarterly* (3 volumes). Began with Volume 4, January 1897 and continued to Volume 5, April 1898. Continued thereafter as *The Louisville Journal of Surgery and Medicine.*

43. *The Louisville Journal of Surgery and Medicine.* Editors: Joseph M. Mathews and H. Horace Grant. Monthly. A continuation of *Mathews' Quarterly Journal of Rectal and Gastro-Intestinal Diseases* (five volumes). Began with Volume 5, June 1898 and continued to Volume 6, July 1899. In August 1899 it united with *Louisville Medical Monthly,* forming *The Louisville Monthly Journal of Medicine and Surgery.*

44. *Southern Journal of Osteopathy.* Published

monthly by the Southern School of Osteopathy (Franklin). Volume 1 to 2, February 1898 to December 1899.

45. *The Louisville Monthly Journal of Medicine and Surgery.* Editors: Joseph M. Mathews and H. Horace Grant *et al.* Formed by the union of *Louisville Medical Monthly* with *The Louisville Journal of Surgery and Medicine* (six volumes). Began with Volume 6, August 1899 and continued to Volume 23, 1916. Thereafter it became *The Mississippi Valley Medical Journal.*

46. *Homoeopathic Guide* (Louisville). A journal for the people. Edited by A. Clokey *et al.* Monthly. Volumes 1 and 2, May 1895 to February 1899.

47. *Bulletin of the Kentucky State Medical Association* (Louisville). Monthly. A continuation of the *Transactions, Minutes* and *Proceedings of the Kentucky State Medical Association,* which see.

48. *Kentucky Medical Journal.* Being the journal of the Kentucky State Medical Association (Louisville). Monthly. Continuation of the *Bulletin of the Kentucky State Medical Association* (one volume). Began with Volume 2, June 1904 and is current. Volumes 2 to 4 published at Louisville. Volumes 5 to 30 (1905-1932) published at Bowling Green. Published at Louisville again since Volume 31 (1933). The volume for 1936 is No. 34.

49. *The Therapeutic Record* (Louisville). A monthly recorder of the advances of therapeutics. Robert C. Kenner, editor. Volume 1, December 1905 to Volume 14, 1918.

50. *Mississippi Valley Medical Journal.* Journal of the Mississippi Valley Medical Association, continuing *The Louisville Monthly Journal of Medicine and Surgery* (Louisville). Editors: H. Horace Grant *et al.* Began with Volume 24, January 1917 and ended with Volume 27, June 1920. With Volume 27, Number 11, October 1920 it was incorporated into *Medical Life* (New York).

51. *Bulletin of the State Board of Health of Kentucky* (Louisville). Volumes 1 to 17, 1911-1927; resumed publication in August, 1928 with Volume 1, Number 1. With Number 4 of Volume 7 (November, 1934) the title became *Bulletin of the Department of Health* (at head of title: Commonwealth of Kentucky). Edited by the personnel of the Board (later Department) of Health. Current volume is Volume 8 (1936).

52. *Commonwealth of Kentucky. Bulletin of the Department of Health* (Louisville). See *Bulletin of the State Board of Health of Kentucky.*

Publications of Transylvania Professors

Now for a few words about the more distinguished of this unusual group of teachers. I shall take them up in the order of their appointments as professors at Transylvania University, giving, as space is limited, none who joined the faculty after 1850.

Samuel Brown (1769-1830), a graduate of Carlisle College in Pennsylvania who completed his medical education in Edinburgh, was the first Medical Professor of Transylvania University, where he took the chair of Chemistry, Anatomy and Surgery in 1799, later becoming Professor of Theory and Practice. He it was who first introduced vaccination against smallpox in what was then called the West. By 1802 he had already vaccinated upwards of 500 persons, while in New York and Philadelphia physicians were just making their first experimental attempts. He used virus obtained from the teats of infected cows, and used it in Lexington even before Jenner himself could gain the confidence of the people in his own country. The library has his thesis on "Bilious Malignant Fever" (Boston, 1797), and his "Treatise on Yellow Fever" (1800). Dr. Brown was the chief founder (1819) of the famous Kappa Lambda Society of Aesculapius which established chapters in many parts of the United States, and was not only the first medical Greek letter fraternity, but also a very powerful influence in medical matters in general. Its strength at length became its weakness and opposition finally ended its existence. This society published its own medical journal: *The North American Medical and Surgical Journal of Philadelphia,* beginning in 1826. The Army Medical Library possesses a complete file.

Frederick Ridgely (1756-1824), having served as Chief Surgeon of General Anthony Wayne's army in 1794, returned to Kentucky in 1799 and was made Professor of Materia Medica, Midwifery and the Practice of Physic at Transylvania University. With his colleague Samuel Brown, he was the first who taught medicine by lectures in "Western America," Dr. Dudley being one of his pupils. He also had much to do with the administration of the medical department of the university. His writings, chiefly in the medical journals of the state, were usually in the nature of brief reports, there being little comparable to modern scientific articles. The Army Medical Library has all of the journals that contain his material.

Benjamin Winslow Dudley (1785-1870) was distinguished equally as a surgeon and a teacher of surgery. Taking his degree at the University of Pennsylvania in 1806, he continued his studies in London and Paris, and returned to Lexington in 1814 in time to help fight the epidemic of "typhoid pneumonia," and in the following year was made Professor of Anatomy and Surgery at Transylvania. Bladder stone seems to have been unusually prevalent in Kentucky in those days for Dudley, using the lateral method and employing

THE

AMERICAN

MEDICAL GUIDE

FOR

THE USE OF FAMILIES,

IN TWO PARTS,

PART 1st. A *MATERIA MEDICA.* BEING A TREATIES ON ALL THE MOST USEFULL ARTICLES USED AS MEDICINE, INCLUDING THOSE WHICH ARE THE PRODUCE OF OUR OWN COUN-TRY.

PART. 2d *THERAPEUTICS,* OR, THE ART OF CURING THE VARIOUS DISEASES OF THE HUMAN BODY.

TO WHICH IS ADDED

A short description of the constituent parts of

THE HUMAN BODY,

BY THOMAS W. RUBLE. M. D.

RICHMOND, (KY.)

PRINTED BY E. HARRIS, FOR THE AUTHOR.

1810

Fig. 4. Title Page of First Medical Book Published in Kentucky, 1810.

the gorget devised by Cline, cut 225 persons for stone, and lost only six of his cases. He laid great stress on the use of boiled water in operations! He successfully ligated the subclavian artery for axillary aneurysm and the common carotid for intracranial aneurysm. In 1828 he published a report of five successful cases in which he had trephined the skull for the relief of epilepsy due to pressure on the brain. Henderson says that he was probably the first surgeon in the United States to perform this operation. He was indeed ahead of his time. Practically all of his known writings are to be found in the collection of the Army Medical Library, including the "Sketch of the Medical Topography of Lexington and Its Vicinity" (1806) which was evidently his thesis at the University of Pennsylvania for his M. D. His "Observations on the Nature and Treatment of Calculous Diseases" (1836) reports his success in lithotomy, and his other writings show his other achievements.

William Hall Richardson (d. 1846), a fellow student in Philadelphia with Cooke, Drake and Dudley, all of whom are being considered in this article. He served as a Surgeon of Kentucky Volunteers in the War of 1812. With the reorganization of the Transylvania medical school in 1818 he was given the chair of Obstetrics. Professional and personal ill-feeling between him and Dr. Dudley resulted in pamphleteering and finally in a duel which left Richardson with a bullet in his thigh, quite harmless as it proved, but strangely enough with a mutual respect between himself and his erstwhile adversary who thereafter became his warm friend. He must have written few if any papers as there is nothing by him in the Army Medical Library, except possibly brief paragraphs in the journals of his day.

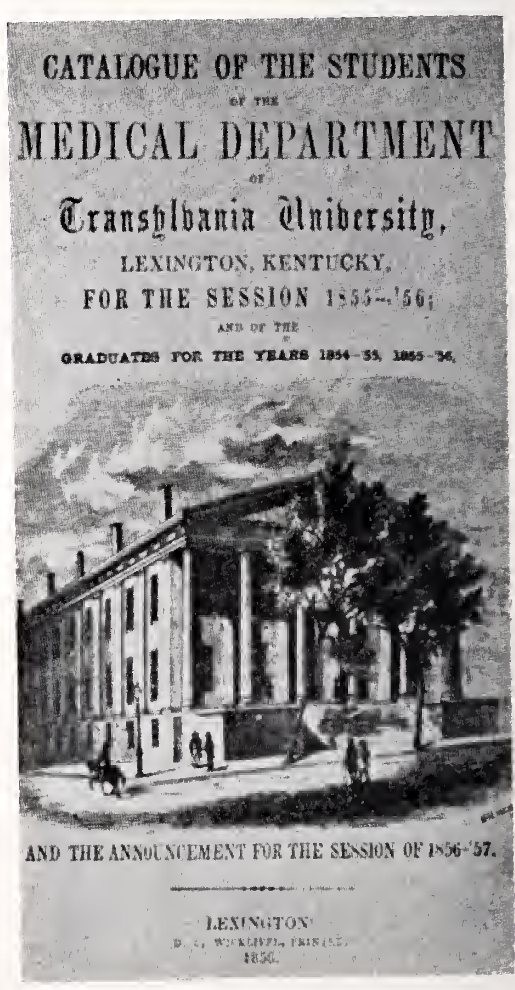
Charles Caldwell (1772-1853) was one of the most colorful medical figures of his time. A native of North Carolina he received his medical education at the University of Pennsylvania. Shortly thereafter he served as a Surgeon in the Army in the bloodless "Whiskey Insurrection" in Western Pennsylvania, 1794. His M. D. was received in 1796 and he began practice in Philadelphia. Though at first Rush's favorite pupil, they were later estranged and as a result Caldwell never became Professor in the Medical Department of the University of Pennsylvania, though holding a chair in the faculty of physical sciences. After declining invitations to take part in the formation of three medical schools in New York, Philadelphia and Baltimore, respectively, he accepted an invitation, 1819, to become a founder of the medical department of Transylvania University. He became Professor of the Institutes of Medicine and Clinical Practice, and held the chair until 1837 when, with other Transylvania professors, he established the Louisville Medical Institute (now University of Louisville). His contribution towards the upbuilding of the Transylvania Library is mentioned elsewhere. His "Autobiography" (1855) gives a splendid picture of the times in which he lived. It has been characterized as "the choicest repository of medical scandal in existence." In it we learn of the disagreements at Transylvania which finally resulted in the closing of the medical school and the establishment of a new school in Louisville. Caldwell was a prolific writer. The Army Medical Library contains no less than forty-nine of his publications. He wrote in other fields than medicine as well. In 1819 he published "The Life and Campaigns of Gen.

Green," while in 1814 he was editor of the *Port Folio* of Philadelphia, containing much of current historical interest. He also edited Delaplaine's "Repository of the Lives and Portraits of Distinguished American Characters."

Lunsford Pitts Yandell (1805-1877) became Professor of Chemistry and Pharmacy at Transylvania in 1831, where he had previously attended lectures. He later shared the chair with Prof. Hezekiah Hulbert Eaton, a graduate of the Rensselaer School (now Rensselaer Polytechnic Institute) of Troy, New York, a trained chemist, which Yandell was not. This arrangement worked well and Dr. Caldwell's contempt of chemistry as a medical science was somewhat counteracted. In 1837 Yandell, with others, went to Louisville as professor of the new medical school, the Louisville Medical Institute (now the University of Louisville). There he taught both chemistry and materia medica. After 1849, when Caldwell had become superannuated, Yandell was also given the chair of Physiology, for which he had a great liking. The change brought a flood of abuse in Caldwell's caustic "Autobiography." In 1859 Yandell accepted a chair in the Medical School of Memphis, Tennessee, and devoted himself to hospital service during the War between the States. In 1862 he was licensed to preach by the Presbytery at Memphis, and in 1864 was ordained pastor of the Dancyville Presbyterian Church. He resigned his pastorate in 1867 and resumed his medical practice in Louisville. He wrote well and often, the Army Medical Library containing some twenty-six of his publications. Aside from his scientific writings he was famous for his skill as a biographer. Many of the sketches of noted Kentucky and other physicians were from his pen, and much of Kentucky's medical history dates back to his work. Some of his medical works are tinged with theology, for example his "Chemistry as Affording Evidence of Wisdom of God" (1835). He was much interested in anesthesia and wrote, among others, papers on "Etherization" (1848) and "On the progress of Etherization" (1849). His "How Louisville Succeeded Lexington as a Centre of Medical Education" (1852) gives his account of what happened.

David Wendel Yandell (1826-1898), son of Dr. Lunsford Pitts Yandell, followed in his father's footsteps. A surgeon and teacher of the first rank, he was a distinguished editor and writer. The Army Medical Library contains more than a dozen of his books and the bulk of his editorial writings. He was President of the American Medical Association in 1871, and held memberships in many other scientific societies. During the War between the States he served on General Albert Sidney Johnston's staff as Medical Director of the Army of the West.

Daniel Drake (1785-1852), a colleague, but personal rival of Dr. Dudley, was one of the great medical figures of his day, though the son of an illiterate pioneer, and born in a log cabin. Educated at the University of Pennsylvania, he was appointed Professor of Materia Medica at Transylvania. He was successively professor at the Medical College of Ohio (1819); a second time at Transylvania (1823), this time occupying the chair of Medicine; the Jefferson Medical College (1830); the Medical Department of the Cincinnati College (1835); the University of Louisville (1840); and again at the Medical College of Ohio (1849). His first publication was the now rare "Natural and Statistical View or Picture of Cincinnati and the Miami Country" (1815), which is interesting as the forerunner of his *magnum opus*, "A Systematic Treatise, Historical, Etiological, and Practical, on the Principal Diseases of the Interior Valley of North America as They Appear in the Caucasian. African, Indian, and Esquimaux


CATALOGUE OF THE STUDENTS

OF THE

MEDICAL DEPARTMENT

OF

Transylvania University,

LEXINGTON, KENTUCKY,

FOR THE SESSION 1855-'56;

AND OF THE

GRADUATES FOR THE YEARS 1854-55, 1855-56,

AND THE ANNOUNCEMENT FOR THE SESSION OF 1856-'57.

LEXINGTON:

1856.

Fig. 5. Title Page of Catalogue of Medical Department of Transylvania University of Lexington, Kentucky, for 1856. This was the Last Year of the Medical School's Existence.

Varieties of Its Population" (1850). The latter is the most important contribution to the natural history of malaria published up to that time. It reveals personal observation, literary research and mature reflection. The Army Medical Library contains not only these two works but some 25 other publications from his pen. Drake founded *The Western Journal of the Medical and Physical Sciences* (1828), it being a continuation of the *Western Quarterly Reporter of Medical, Surgical and Natural Sciences* (1822-1823) and the *Ohio Medical Repository* of Cincinnati (1826-1827). In both of these publications are found material by early Kentucky masters. Drake's writings are "most distinctly and peculiarly American books, in subject, mode of treatment, style, and composition" (Billings).

Charles Wilkins Short (1794-1863) of Woodford County, Kentucky, joined the Transylvania faculty in 1825, and for ten years held the office of Dean. In 1838 he left Transylvania and became Professor of Botany and Materia Medica at the Louisville Medical Institute (now the University of Louisville), holding his chair until 1849 when he was elected Professor Emeritus. He was the nephew of Dr. Frederick Ridgely (see above) and studied with him in Philadelphia, receiving the M. D. degree of the University of Pennsylvania in 1815. His preliminary training had been in Kentucky; he graduated at Transylvania in 1810. His writings in the *Transylvania Journal of Medicine and the Associated Sciences,* of which he was co-editor with Dr. Cooke (see below), were many. His "Observations of the Botany of Illinois" was published in *The Western Journal of Medicine and Surgery.* 1845. Besides these, the Army Medical Library has his "Instructions for the Gathering and Preservation of Plants for Herbaria" (1833) and "Duties of Medical Students during Attendance on Lectures" (1845).

John Esten Cooke (1783-1853) who had first studied medicine under his father, Surgeon Stephen Cooke of the Revolutionary Army, graduated at the University of Pennsylvania in 1805. He was one of the two founders of the Medical School of the Valley of Virginia, in his native town of Winchester, Virginia, in 1827, but three years later became Professor of the Practice of Medicine at Transylvania University, succeeding Dr. Drake, who strongly opposed his doctrines. With Dr. Short (see above) he was co-editor of *Transylvania Journal of Medicine and the Associated Sciences.* In 1837 he accepted the chair of the Theory and Practice of Medicine at the Louisville Medical Institute, now the University of Louisville. Dr. Cooke was famous for his theory of the universal origin of disease, which was that disease is caused by cold or malaria, resulting in congestion of the vena cava. According to him all autumnal and malarial fevers were but variations of one disease condition, and even such maladies as yellow fever, dysentery, plague and cholera were simply varied conditions of congestion of the vena cava. As a remedy calomel was his chief reliance. The Army Medical Library has his "Treatise on Pathology and Therapeutics" (1828), being the first systematic work issued by a Transylvania professor, his "Introductory Lecture, Delivered to the Medical Class of Transylvania University in 1838," and his thesis (1805) containing his "Account of the Inflammatory Bilious Fever of 1804 in Loudoun County, Virginia," in which his theory is set forth.

John Eberle (1787-1838) was born of German parents at (probably) Hagerstown, Maryland and was twelve years of age before he could speak English. He graduated at the University of Pennsylvania, 1806, his thesis being on "Animal Life." He practiced in his native town until the War of 1812 in which he served as a Surgeon of the Lancaster Militia, being present at the battle of Baltimore (1814). Removing to Philadelphia he helped found the *American Medical Recorder* (quarterly), 1818, which received recognition in Europe as well as America and won him membership in the German Academy of Natural Sciences. In 1818 he also published "Botanical Terminology" and in 1823 his "Treatise of the Materia Medica and Therapeutics," a standard text which went through five editions. He was one of the founders of the Jefferson Medical College (1825) of Philadelphia, becoming its Professor of Materia Medica. "Eberle's Notes" became a kind of *vade mecum* for the students, and a second edition appeared in 1832. From this grew his "Notes of Lectures on the Theory and Practice of Medicine" (second edition, 1834, with four subsequent editions), a text characterized by original thought. From 1824 to 1826 he was editor of the *American Medical Review.* In 1830 he accepted Dr. Drake's offer to organize the medical faculty of Miami University, designed as a competitor of the Medical College of Ohio. By the time he arrived in Cincinnati (1831) the two schools had consolidated and he found himself in the conjoined faculty. In 1832 they founded the *Western Medical Gazette* and in 1833 Eberle published his "Treatise on the Diseases and Physical Education of Children." Eberle's report on the cholera outbreak in Cincinnati was published in the *Cincinnati Daily Gazette* for June 26, 1832. In 1837 he accepted the chair of the Theory and Practice of Medicine at Transylvania University and became one of the editors of the *Transylvania Journal,* but his untimely death occurred before he had completed a full academic year. The Army Medical

Library contains all of Eberle's important contribution. His two-volume "Treatise on the Practice of Medicine" first appeared in 1830 and was several times revised, last of the revisions appearing in 1849 with additions by Dr. Gordon McClellan (father of the general). His "Treatise on the Diseases and Physical Education of Children" was revised and republished by his former colleague, Dr. Thomas Duche Mitchell in 1850.

Nathan Ryno Smith (1797-1877), son of Dr. Nathan Smith, the founder of the Dartmouth and Yale Medical Schools, received his M. D. at Yale in 1823, in his inaugural thesis defending the view that the effects of remedies and disease are due to the absorption into the blood and not to an impression on the nervous system, as many eminent writers then maintained. After practicing a year in Burlington, Vermont, he was appointed Professor of Surgery and Anatomy at the University of Vermont. In the following year he was appointed Professor of Anatomy at the Jefferson Medical College, among his pupils being Samuel David Gross and Washington Lemuel Atlee. In 1825 he published in New York an "Essay on Digestion," while in the same and the following year he edited, with the cooperation of his father, the *American Medical Review*. In 1827 he founded the *Philadelphia Monthly Journal of Medicine and Surgery* which in the following year was merged into the *American Journal of the Medical Sciences*. In 1827 he accepted the chair of Surgery in the University of Maryland and therewith began his long and eventful career in Baltimore. In 1829 his "Diseases of the Internal Ear" was published, which was his translation of a French work by J. A. Saissy, with an introduction by himself. In 1830 and again in 1846 he delivered the annual oration before the Medical and Chirurgical Faculty of Maryland. In 1830 he began *The Baltimore Monthly Journal*, which contained much of his writing, for example. "Description of an Apparatus for the Treatment of Fractures of the Thigh and Leg by Smith's Anterior Splint." He was a frequent contributor to the *American Journal of the Medical Sciences, the Maryland and Virginia Medical Journal,* and others. In 1832 appeared his great work "Surgical Anatomy of the Arteries," with second edition in 1835. In 1867 his "Anterior Suspensory Apparatus in the Treatment of Fractures of the Lower Extremity," and in 1869 his whimsical "Legends of the South, by Somebody Who Wishes to Be Considered Nobody." His lengthy work on surgery remained unfinished at his death. In 1838 he accepted the chair of the Practice of Medicine at Transylvania University, continuing at the same time to retain his Baltimore practice and teaching position, as he was able to reside in Lexignton for four months of the year for the sessions of Transylvania and then return to Baltimore for the other eight. In 1867 he toured Europe and was everywhere received as the "Nestor of American Surgery." All of the works above mentioned are in the Army Medical Library, as well as numerous other less important communications in various journals.

James Conquest Cross (1798-1855), a native of Lexington and a graduate of Transylvania in the class of 1821, succeeded Dr. Daniel Drake as Professor of Materia Medica in that institution. After quarreling with the powerful Dr. Dudley, he resigned and practiced for a time at Courtland, Alabama, later becoming professor at the Medical College of Ohio. In 1837 he resigned and took the chair of Therapeutics at Transylvania at the express wish of Dr. Dudley. "Cross was accused of every crime in the calendar from drunkenness to rape" (Juettner). In the law suits which followed he was represented by Henry Clay. His "Appeal to the Medical Profession of the United States" was published in 1846. After being a wanderer for some years, lecturing to medical classes in various places, he settled in Memphis in 1850 and founded the short-lived Memphis Medical Institute. Besides his "Appeal" the Army Medical Library has his "Thoughts on the Policy of Establishing a School of Medicine in Louisville" (1834): "Inaugural Discourse on Medical Eclecticism" (1835); "Address on American Literature" (1839); "Scarlatina" (n.d.), as well as four or five writings in defense of his character and attacking his critics.

Robert Peter (1805-1894) was brought from Cornwell to Pittsburgh by his parents and there, while employed in an apothecary shop, developed a taste for chemistry. He acquired training in this field at the Rensselaer School (now Rensselaer Polytechnic Institute) of Troy, New York, and in 1831-1831 delivered lectures on chemistry in the Western University of Pennsylvania. In 1833 he was installed in the chair of chemistry at Transylvania and there studied medicine, receiving his diploma in 1834. He continued at the head of the chemistry department until the closing of the school in 1857, being dean for the last decade. Mention is made elsewhere of his part in the purchase of the books for the Transylvania Library. His efforts resulted in the establishment of the Kentucky Geological Survey by the Legislature in 1854, the first state undertaking of its kind in the West. He was first to show that the productivity of the bluegrass soils of Kentucky is due to their high phosphorus content. When Transylvania University became Kentucky University, Dr. Peter declined the presidency, though retaining the title of Professor Emeritus of Chemistry. His works in the Army Medical Library include: "Thoughts on

Some of the Applications of Chemistry to Medicine" (1834); "On the Application of Galvanic Electricity to Medicine" (1836); "On the Influence of Caloric on the Living Animal Body" (1838). "Chemical Examination of Urinary Calculi, etc." (1846), and others, some ten in all. Dr. Peter wrote for the Filson Club (1854) an excellent monograph on the history of Transylvania and had prepared the manuscript of another on the Medical Department of that institution, which was published after his death by his daughter, Johanna Peter (1906). He was a frequent contributor to the *Transylvania Journal,* and from 1867 to 1868 was assistant editor of the *Farmer's Home Journal.* During the War between the States he was in charge of military hospitals in Lexington.

Thomas Duche Mitchell (1791-1865) early acquired a taste for chemistry by working in a pharmacy in his native Philadelphia. He took his degree in medicine at the University of Pennsylvania in 1812. He began his publications while he was still an undergraduate and in the year of his graduation was made Professor of Animal and Vegetable Physiology in St. John's College (Philadelphia), and in the following year was appointed physician to the Philadelphia Lazaretto. In 1819 he published "Medical Chemistry or a Compendious View of the Various Substances Employed in the Practice of Medicine," and as a result was offered the professorship of chemistry in the Ohio University at Athens, but declined it. He was an early advocate of total abstinence from alcohol and in 1826 made an unsuccessful attempt to form a total abstinence society. In 1831 he accepted the chair of Chemistry at Miami University but before the year went to a similar position at the Medical College of Ohio. In 1832 he published his "Elements of Chemical Philosophy," a volume of some 600 pages, and his "Hints on the Connection of Labor with Study, as a Preventive of Diseases Peculiar to Students." In 1832-1833 he was editor of *The Western Medical Gazette.* He went to Louisville in 1837 as Professor of Chemistry at the Louisville Medical Institute, but a month later took the same chair at Transylvania. In 1839 he was transferred to the chair of Materia Medica and Therapeutics which he held for a decade. In 1849 he became Professor of Medicine, Obstetrics and Medical Jurisprudence at the Philadelphia College of Medicine and in the following year published his "Materia Medica and Therapeutics," of which a revised edition appeared in 1857. He also edited Dr. John Eberle's "A Treatise on the Diseases and Physical Education of Children." In 1857 he became Professor of Materia Medica at the Jefferson Medical College. At the time of his death he left unpublished a work of 600 pages on "Fevers of the United States." He contributed biographies of Gross and Eberle in "Lives of Eminent American Physicians" (1861). Besides the above works, the Army Medical College contains many other publications of this prolific writer, seventeen in all, as well as his contributions to the journals of which he was editor.

A

CATALOGUE

OF THE

OFFICERS AND STUDENTS

OF THE

LOUISVILLE MEDICAL INSTITUTE.

LOUISVILLE, (KY.) JANUARY, 1838.

LOUISVILLE:

PRENTICE & WEISSINGER.

1838.

Fig. 6. Title Page of Catalogue of First Session of Louisville Medical Institute, 1838. In 1845 this Institution was Chartered by the Kenucky Legislature under the Present Name, The Medical Department of the University of Louisville.

James Mills Bush (1805-1875) a native of Frankfort, Kentucky, and a graduate of Centre College of the class of 1828, acquired his medical education at Transylvania under Prof. Dudley, graduating with honors in 1833. He became Dudley's assistant in Anatomy and Surgery and in 1844 became Professor of Anatomy, while Dr. Dudley retained the chair of Surgery. In 1850 he left Transylvania for the new Kentucky School of Medicine (now University of Louisville). Though not the author of any lengthy treatise or text, he contributed much to *The Transylvania Journal.*

In the Army Medical Library we find "An Introductory Lecture to the Dissecting Class of Transylvania University" (1840), and his "Observations on the Operations of Lithotomy: Illustrated by Cases from the Practice of Prof. B. W. Dudley" (n. d.). His writings in *The Transylvania Journal* cover such topics as epilepsy, "insidious inflammation of the pia mater," pressure as applied by means of the bandage, dissection of an idiot's brain, and several papers on lithotomy.

Constantine Samuel Rafinesque (1783-1840), the gifted son of a prosperous French merchant, was born at Galata, a suburb of Constantinople. His father died while on a voyage to the United States and the boy was brought up by his mother. Endowed with a boundless enthusiasm for the study of nature, he early began a systematic collection of a herbarium. He was aided by Dr. Benjamin Rush and others in Philadelphia. For a few years he was secretary of the American Consul in Palermo, Sicily, always continuing his study of plants. He returned to the United States in 1815. In 1818 he was appointed Professor of Botany, Natural History and Languages at Transylvania, where for eight years he was a brilliant teacher. Thereafter he lived in Philadelphia, continuing to the end of his life his studies in botany and ichthyology. The Army Medical Library contains a number of his books in English, Italian and French, dealing chiefly with the flora of the places in which he lived or traveled. His biography is well written in one of the publications of the Filson Club of Louisville. Though not a physician, this genius had not a little to do with the training of physicians at the university in which he taught.

The University of Louisville

In the early 1830's it began to be felt by some of the medical faculty of Transylvania University that the school should be moved to Louisville. The reasons given by Dr. Yandell, one of the leaders in the movement, were that Louisville had replaced Lexington as the metropolis of the state, and that Lexington had no hospital so that only didactic lectures could be given. It seems that in addition there had been dissensions within the Transylvania faculty. In 1837 the city of Louisville chartered a new medical school, the Louisville Medical Institute. It was not the direct successor of Transylvania, though in effect it became such, because Transylvania closed some twenty years thereafter. The following was the first faculty of the Louisville Medical Institute:

Dr. Charles Caldwell, Professor of the Institutes of Michigan
Dr. John Esten Cooke, Professor of Theory and Practice of Medicine
Dr. Lunsford Pitts Yandell, Professor of Chemistry
Dr. Henry Miller, Professor of Obstetrics
Dr. Jedediah Cobb, Professor of Anatomy
Dr. Joshua Barker Flint, Professor of Surgery (replaced in 1839 by Dr. Samuel David Gross)

Of these Drs. Yandell, Caldwell and Cooke had come from the Transylvania faculty, leaving Drs. Dudley, Richardson and Short at the older institution. Dr. Cobb had come from the Medical College of Ohio. Dr. Flint from practice in Boston, and Dr. Miller from practice in Harrodsburg.

The first class numbered 80 students and 27 men were graduated. During that year there were 230 students at Transylvania, almost its usual strength. In its second year, the Medical Institute of Louisville had 120 students and in the third year 205. In 1845 the Legislature of Kentucky chartered the Louisville school and gave it the name of the University of Louisville. In that year it had 353 students, and in the year following 406. The school has continued ever since without interruption and with continuing success. In 1908 the four other medical schools of Louisville were consolidated with the University of Louisville (see above).

The Army Medical Library contains, *inter alia,* an anonymous pamphlet entitled: "Some Account of the Origin and Present Condition of the Medical Institute of Louisville, with Remarks on a Late Rejected Report" (Louisville, 1842), with several bits of interesting history.

Publications of Louisville Professors

Several of the noted early professors of the Louisville faculty have already been mentioned, having been members of the Transylvania staff. Some of the others were the following:

Henry Miller (1800-1874) graduated in medicine at Transylvania in 1821, and followed additional lectures in Philadelphia thereafter. After practicing in Harrodsburg he entered into the organization of the Louisville Medical Institute in 1835, becoming Professor of Obstetrics, and, with a few interruptions, held the chair in this institution and the Louisville Medical College until the end of his life. He was an able obstetrician and an early advocate of anesthesia in labor. His clear and forceful writings are well represented in the Army Medical Library, beginning with his thesis "On the Relation between Sanguiniferous and Nervous Systems" (1822). There are in all some thirteen of his communications, chiefly in clinical obstetrics. There is also his oration on the anniversary of the Kappa Lambda Society of Hippocrates, delivered in Lexington in 1822—a rare item.

Jedediah Cobb (1800-1861) was a native of Maine and graduate of Bowdoin College in 1823. After having taught at the Medical College of Ohio, he resigned to accept the chair of Anatomy

at the Louisville Medical Institute. He held this professorship for only two years and was replaced by Dr. Gross. In 1852 he returned, with Dr. Drake, to the Medical College of Ohio, but of account of ill health had to resign after one session. Gross admired him greatly as a teacher and anatomist, as we read in Gross's "Autobiography." He, apparently, did not reduce his knowledge and experience to writing, for nothing from his pen is to be found in the Army Medical Library.

Joshua Barker Flint (1801-1864), a native of Massachusetts and M.D. of Harvard, 1825. He practiced medicine in Boston from the time of his graduation until 1837 when he accepted the chair of Surgery in the newly founded Louisville Medical Institute. He was succeeded by Gross. He was the original organizer of the Kentucky School of Medicine of Louisville. It ran for the first year as the Medical Department of the Masonic University of Kentucky, a corporation formed from Funk Seminary at LaGrange, Kentucky. The Army Medical Library has his address to the students of the Louisville Medical Institute (1838); his "Sketches of Military Surgery" (1852); "Introductory to Surgical Instruction &c" (1854); and other surgical papers such as one before the Kentucky State Medical Society in 1859. From 1832 to 1835 Flint was co-editor of the *Medical Magazine* of Boston.

Samuel David Gross (1805-1884) was one of the most famous medical men who has ever been associated with Kentucky. He was born near Easton, Pennsylvania, completed his general education at the Lawrenceville Academy, and graduated at the Jefferson Medical College in 1828. In the same year he published several translations from French and German, including Bayle and Hollard's "A Manual of General Anatomy," Hatin's "A Manual of Practical Obstetrics," Hildebrand's "Treatise on Contagious Typhus," and Tavernier's "Elements of Operative Surgery." He was appointed demonstrator of anatomy at the Medical College of Ohio in 1833 and became Professor of Pathological Anatomy at the Cincinnati Medical College when established by Drake two years later. In 1839 he published the first systematic study in English in his chosen field, "Elements of Pathological Anatomy," which made him famous at home and abroad. In 1840 he was elected Professor of Surgery at the University of Louisville and became the most celebrated surgeon in the South. He was called to the University of the City of New York in 1850 to take Dr. Valentine Mott's place, but not liking the city returned to Louisville after about a year. In 1851 he published "A Practical Treatise on the Diseases and Injuries of the Urinary Bladder, the Prostate Gland, and the Urethra" which at once became the accepted authority. The last edition of this work, edited by his son, Samuel Weissell Gross, appeared in 1876 and was still a standard textbook a decade later. In 1854 he published "A Practical Treatise on Foreign Bodies in the Air-Passages," the first attempt to systematize knowledge on the subject. In 1859 his "System of Surgery, Pathology, Diagnostic, Therapeutic and Operative," the greatest surgical treatise of his day, appeared. At the outbreak of the War between the States he wrote "A Manual of Military Surgery" (1861) which in 1874 was translated into Japanese. In the same year he edited "The Lives of Eminent American Physicians and Surgeons of the Nineteenth Century," writing a number of the articles himself. He was a founder of the American Medical Association and other scientific bodies. He was famous in Europe as well as America, and received honorary degrees from both Oxford and Cambridge. Some sixty books and articles, including those noted above, from his prolific and skillful pen are in the Army Medical Library. Just outside the building may be seen the bronze statue of Dr. Gross, erected in 1895 in accordance with the Act of Congress. Gross was an enthusiastic supporter of the Army Medical Library in its early days. With Drs. S. Weir Mitchell and William W. Keen he introduced resolutions expressing the profession's "appreciation of the work of the institution."

Alban Gold Smith (1788-1865), generally called Alban Goldsmith, a native of Danville, was a pupil of Dr. Ephraim McDowell, and is said to have been present when McDowell performed his first ovariotomy. In 1823 he performed ovariotomy himself, the second man to do so in the United States. He studied under Civiale in Paris and on his return performed Lithotripsy (Civiale's operation) the first time it was done in this county. In 1833 he secured a charter from the Kentucky Legislature for the Louisville Medical Institute. This, however, he never used, and the charter was taken over in 1837 by the seceders from the Transylvania Medical School. He was a professor at the Medical College of Ohio, leaving in 1837 to become Professor of Surgery at the College of Physicians and Surgeons of New York. The Army Medical Library has his "Lithotripsy, or the Breaking of Stone in the Bladder" (1843), and his "Diseases of the Genito-Urinary Organs" (1857), two valuable works of a man who left but few writings.

Tobias Gibson Richardson (1827-1892) of Lexington, Kentucky, was one of Dr. Gross's private pupils, graduating at the University of Louisville in 1848. For the next eight years he served there as demonstrator of anatomy and in 1854 published his "Elements of Human Anatomy," a text long standard in Southern schools. In 1856

he acted as co-editor of *The Louisville Medical Review*. He accepted the chair of Anatomy at the Medical Department of Pennsylvania College in 1856, declining in the same year the professorships at the Kentucky School of Medicine and the New York Medical College. In 1858 he became Professor of Anatomy at the University of Louisiana (now Tulane) in New Orleans. He served in the War between the States as a Surgeon, becoming finally Medical Director on General Bragg's staff. He was president of the American Medical Association in 1877, being a strong advocate of the establishment of a Federal Department of Health and the national control of matters of quarantine. The journal that he edited is found complete in the Army Medical Library, also several editions of his Anatomy and his address (1878) before the American Medical Association.

Austin Flint (1812-1886), one of the most eminent American practitioners of the century, received his education in his native Massachusetts at Amherst and Harvard. He was Professor of Medical Theory and Practice at the Rush Medical College, Chicago, 1844-1845 and in the latter year established *The Buffalo Medical Journal*, which he conducted for ten years. In 1852-1856 he occupied the chair of Medicine at the University of Louisville, and from 1858-1861 in the New Orleans Medical College. In 1861 he became Professor of Pathology and Practical Medicine at the Long Island College Hospital and cooperated with others in founding Bellevue Hospital Medical College. He was President of the American Medical Association 1883-1884. Forty-three of his papers and books, covering a wide variety of subjects, may be seen in the Army Medical Library.

Theodore Stout Bell (1807-1884) of Lexington, despite early hardships, managed to graduate at Transylvania in 1832, being a pupil of Dr. Dudley. He sought to bring Transylvania to Louisville, and when this could not be done, became a founder of the Louisville Medical Institute. His connection with this institution continued and in 1857 he was made Professor of the Science and Art of Medicine and Public Hygiene at the Univerity of Louisville, a position that he held until his death. He was on the editorial staff of the *Louisville Journal* when George Dennison Prentice was its editor. In 1838 with the elder Yandell, he founded *The Louisville Medical Journal*, and in 1840 became also a founder of *The Western Journal of Medicine and Surgery*. He was a man of wide knowledge and a voluminous writer. The Army Medical Library contains a large number of his editorials and journal articles, as well as about a dozen addresses, treatises and lectures.

William L. Sutton (1797-1861), who graduated at Transylvania in 1818, though not a professor at either one of the Kentucky medical schools, must be reckoned as an important medical pioneer, for he was the leading spirit in organizing the State Medical Society, of which he became the first President (1851). He was in 1858-1859 First Vice-President of the American Medical Association. Associated with him in the work of organizing the Kentucky Medical Society were the three secretaries, Drs. Edward Howe Watson, J. M. Mills and W. C. Sneed, all of Frankfort. It was due chiefly to Dr. Sutton's influence that the first law was passed requiring the registration of births and deaths, and he was the first State Registrar of Vital Statistics of Kentucky. He published a number of valuable reports. The Army Medical Library contains not a few of Sutton's contributions, for example his prize essay on Scrofula (1846) submitted to the Medical Society of Tennessee; his "History of the Disease Usually Called Typhoid Fever, As It Appeared in Georgetown (Ky.) and Its Vicinity" (1850); "Report on the Epidemics of Tennessee and Kentucky" (1852); and "Report on a Uniform Plan for Registration of Births, Marriages and Deaths" (1859).

Walter Brashear (1776-1860) offers a good example of the great physician who neglected writing of his work. This fine old practitioner of Lexington and graduate of Transylvania (1822) shed luster on the surgery of his town and state. He was not a professor at a medical school, but in 1806, while practicing at Bardstown, he had successfully amputated through the hip-joint, eighteen years before the same operation was performed by Valentine Mott! But, alas, the collections of the Army Medical Library, like other libraries, contains nothing from his pen, though not a little about his work by others. For more than half a century Brashear's great work lived only in tradition. Similarly we have nothing on his skill as a lithotomist and an operator in skull fractures, both fields being well understood by him, as many a contemporary opinion attests.

Portraits of a number of these early Kentucky physicians are included in the interesting monograph on "Medical Pioneers of Kentucky" by the late Dr. J. N. McCormack, in the *Kentucky Medical Journal* for 1917.

I would be more lacking in sentiment than is usual in a Kentuckian if I did not feel a strong sentimental attachment to the University of Louisville. My father, the late Dr. Enoch Edgar Hume of my native Frankfort, graduated there in 1869. His brother, Dr. Lewis Nicholas Hume graduated in 1874. My maternal uncle, Dr. John Glover South, received his M.D. there in 1897. My father's uncle, Dr. Joseph Hume, graduated there in 1857 and his two sons, Dr. Joseph Hume, Jr,

and Dr. Waverly McGee Hume, followed him in 1880 and 1882, respectively, while my father's grand-uncle, Dr. Joseph McGee, was associated with the University in its early days. These members of my family studied under some of the illustrious men mentioned in this paper, of whose fame all Kentuckians are justly proud.

Such then is the collection of early Kentucky medical literature preserved in the national medical library of the United States. The books and papers may be examined and read by visitors to the library. The future medical historian of our state has the lion's share of his task already done for him, for the material is largely collected. His is the task to weave together the threads thus ready to be used.

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Kentucky State Medical Association Bulletin. 41

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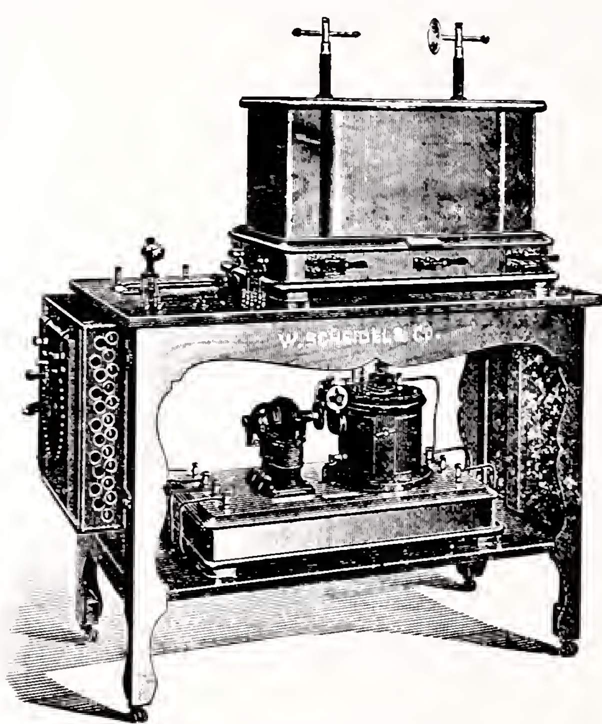

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The sterile rubber tuhe is used for connecting the needle to the syringe to prevent tearing the flesh of the patient or hreaking tbe point of tbe syringe should the patient struggle during tbe injection of the serum.

The entire package, with needle and plunger, is carefully sterilized in the lahoratory hefore the syringe is filled.

At every stage in the preparation and administration of Mulford's Antitoxin is perfect asepsis insured. Air never comes in contact with the serum. Contamination is prevented; injection of air is impossible.

Report from the Minneapolis City Hospital

"We have had during the year (ending December 31st) 170 cases of diphtheria with two deaths, these being in a moribund condition when brought in the hospital. Such results have been obtained by a very liberal use of Antitoxin.

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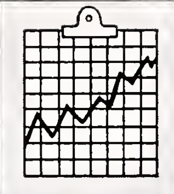
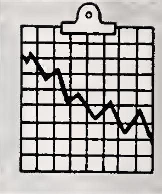


CASE DISCUSSIONS

From The
University of Kentucky Hospitals



University of Kentucky Medical Center

The Respiratory Distress Syndrome In A Premature Infant

John J. Boehm, M.D.*

I. M., a premature infant female, was admitted to the University of Kentucky Hospital at 16 hours of age. She was delivered at another hospital by cesarean section because of severe maternal vaginal bleeding diagnosed as abruptio placenta. Gestation was estimated at 33 weeks. This was the mother's second pregnancy. The first pregnancy apparently went to term, and the older sibling was delivered vaginally without incident and is now living and well. This pregnancy was marked by intermittent edema of the lower extremities and intermittent pyuria. The infant was said to be vigorous at birth. Breathing was spontaneous and her color was good. Birth weight was 3 pounds and 8 ounces. At six hours of age feedings of 7.5 ml. of a commercially prepared formula were begun and given every two hours by medicine dropper. Shortly after the first feeding the infant was noted to have grunting respirations with minimal subcostal and intercostal retractions. At 12 hours of age the infant regurgitated a portion of her feeding through her nose. Because of the increasing respiratory distress the infant was transferred to the University Hospital.

Physical examination on admission revealed a premature, newborn infant female whose color was pink with the exception of dusky extremities. Weight was 1555 grams; respiratory rate, 80 per minute; heart rate, 100 per minute; and temperature was below 94°F. Expiratory grunting was noted and there were subcostal and intercostal retractions. Except for decreased air entry on auscultation of the chest, the remainder of the physical examination was within normal limits. Admitting impression was prematurity with the respiratory distress syndrome.

Hospital Course: The infant was placed in an Isolette, all oral feedings were discontinued and an intravenous infusion of 10 per cent glucose in water to which 5 mEq sodium bicarbonate per 100 ml of solution were added. The infusion was given at the rate of 65 ml/Kg per 24 hours through the umbilical vein. Eight units of regular insulin were also added to the intravenous fluids to run over the 24 hour period. A chest film shortly after admission revealed a granular pattern of the pulmonary parenchyma bilaterally with an air bronchogram and a widened superior mediastinum (see Fig. 1).

Approximately thirty minutes after admission the infant stopped breathing. With resuscitation by positive pressure mask, respirations resumed with continuing subcostal and intercostal retractions and expiratory grunting. Laryngoscopy at that time revealed curds of milk exuding from the larynx. Following this, the infant had several episodes of apnea of varying duration. The oxygen concentration necessary to keep the infant free of cyanosis increased gradually from an initial concentration of 30 per cent to 55 or 60 per cent. Auscultation of the lungs after the apneic spells revealed crepitant rales in the left lung base with very poor air exchange. The respirations gradually became more rapid up to 100 per minute. Twenty-four hours after admission respirations became shallow and the infant's color

* *Department of Pediatrics, University of Kentucky Medical Center, Lexington, Kentucky*

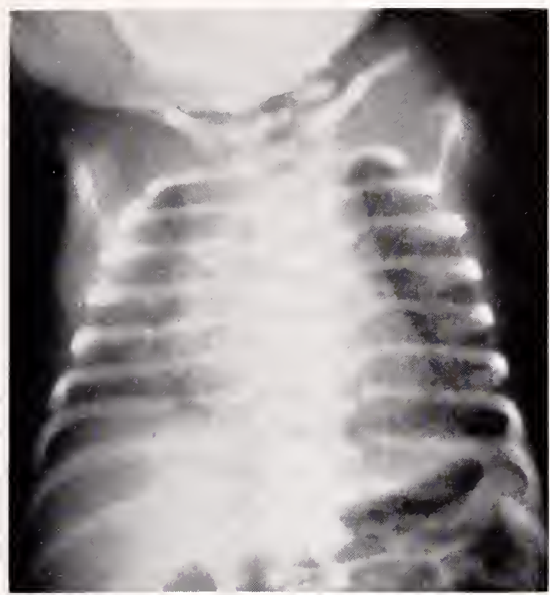


Figure 1. Roentgenogram of the chest demonstrating bilateral reticulogranular pattern of the pulmonary parenchyma, the air bronchogram, and a widened superior mediastinum.

was then dusky. Air exchange was very poor by auscultation, and an increasing amount of crepitant rales were audible bilaterally. Each time the infant became apneic 10 to 15 minutes of resuscitation with the positive pressure mask were necessary to alleviate the cyanosis. Even with these most diligent efforts at resuscitation the color remained somewhat dusky. Twenty-six hours following admission the infant had an apneic spell from which she could not be resuscitated. She was pronounced dead at 42 hours of age. Permission for postmortem examination was obtained and at necropsy other than prematurity, the significant findings were limited to the lungs. Microscopic examination of both lungs showed severe atelectasis and marked hyaline membrane formation with minimal hemorrhage and pneumonitis (see Fig. 2).

Discussion

By whatever criteria used this infant demonstrates the respiratory distress syndrome (RDS). Usher has used the criteria of chest retraction, expiratory grunt, and decreased air entry on auscultation persisting beyond three hours in the absence of co-existing disease.[1] Silverman has used the criteria of synchronization of the upper chest, retraction of the lower chest, xyphoid retraction, dilation of the nares and expiratory grunt in diagnosing respiratory distress.[2] Miller has used expiratory grunt, resting respiratory rate above 65 per minute between the first and 30th hour of age, and an increase in respiratory rate between one and thirty hours of age of more than fifteen per minute over highest rate in the first hour.[3] The characteristic x-ray picture of reticulogranular pattern, the air bronchogram, and the widened supeior mediastinum helps to confirm the diagnosis (see Fig. 1).[1]

At the present time the respiratory distress syndrome in newborn infants is at best a confused issue. The etiology and the pathogenesis are certainly not clear. There is also the unsettled question as to whether or not all infants with signs of respiratory distress in the neonatal period should be included under the term respiratory distress syndrome or whether only those infants who have or who are suspected to have hyaline membrane disease with atelectasis and pulmonary hyaline membranes (see Fig. 2) should be so designated. In addition, there is the problem of treatment about which there is no more agreement than on etiology, pathogenesis and the diagnostic criteria.

Etiology: Prematurity is the most obvious etiologic factor associated with the disease since only 10 per cent of the cases of the respiratory distress syndrome occur in full-term infants. About 14 per cent of all premature infants have the respiratory distress syndrome. In the one thousand to fifteen hundred gram weight group, about 50 per cent will demonstrate RDS whereas in the two thousand to twenty five hundred gram group, only 5 per cent will be so efected. Maternal diabetes, toxemia, and other causes of prematurity are commonly associated with the syndrome. Infants who have demonstrated fetal distress prior to

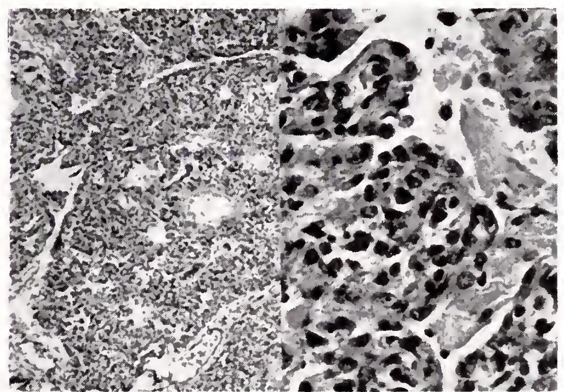


Figure 2. Photomicrographs from lungs of patient I.M. Left, under low power, demonstrating marked atelectisis. Right, under high power, demonstrating hyaline membrane formation.

birth or those in whom the delivery was complicated by placenta previa or abruptio placenta show a much higher incidence of the respiratory distress syndrome. Cesarean section per se does not apear to be associated with an increase in RDS unless it is associated with one of the above mentioned factors or just prematurity itself.[4] With no special treatment, 50 per cent of infants with RDS die. In the one thousand to fifteen hundred gram group, 66 per cent succumb whereas in the two thousand to twenty-five hundred gram group, 31 per cent of infants with RDS expire. It is of interest that 11 per cent of all premature infant males die of this condition whereas the mortality rate in premature females is only 4 per cent. If one member of twins or triplets is effected, all are effected.[1]

Pathogenesis: In this brief review, pathogenesis will not be discussed in detail. Readers are referred to one of the excellent review articles on this subject.[5,6,7,8,9] Grossly impaired ventilation with the arterial PCO_2 increased is one of the basic problems. In addition to this, arterial PO_2 is depressed. Because in severe cases cyanosis sometimes does not improve with administration 100 per cent oxygen, it is postulated that there are large right to left shunts at either the level of the patent ductus arteriosus, foramen ovale, or the lungs themselves.[10] At catheterization, left to right shunts have also been found as well as bi-directional shunts. Left atrial pressures were found to be low, ruling out the possibility of cardiac failure as cause of the disease.[11] With the retention of CO_2, blood pH values become depressed, resulting in a respiratory acidosis. As the disease progresses metabolic acidosis also occurs. It has been postulated that this is secondary to the decreased oxygen supply with an accumulation of lactic acid. There is also evidence of tissue catabolism as reflected by an increase in serum potassium and serum urea. Recently many other factors have also been implicated in the disease. Among them are peripheral vascular collapse with decrease in blood pressure,[12] clamping of the umbilical cord prior to the onset of respirations,[13] and a lack of the normal alveolar lining layer.[14]

USUAL CLINICAL COURSE: Eighty per cent of the infants who die with RDS succumb between the twelfth and 72nd hour of life. As the disease progresses, the infant becomes more depressed, more irritable, many have increasing cyanosis, increased respiratory rate, more severe retractions, and a more audible expiratory grunt. Dorsal pedal carpal edema not present at birth will occur. Some of the more ominous prognostic signs are retractions and grunting early, rales in the first six hours of life, cyanosis in oxygen after twelve hours of age, liver enlargement after twelve hours of age, apneic spells before forty-eight hours of age, and a decreasing respiratory rate early.[1] If these latter signs do not occur, recovery is more hopeful.

Treatment

At the present time there is no treatment upon which everyone agrees. Perhaps one of the most important factors is to recognize the disease early. Any premature infant, especially one whose delivery has been preceded by maternal toxemia, diabetes, or bleeding is especially suspect. These infants should be observed very closely during the early hours of life. If any suspicion of respiratory distress occurs, feedings should be withheld and the infant kept warm by elevating the temperature of the incubator until the baby's body temperature reaches approximately 97° F axillary. It has been conclusively shown by Silverman that high humidity (80 to 90 per cent relative humidity) is of no value in the treatment of this condition.[15] Oxygen in concentrations necessary to relieve cyanosis even if this concentration exceeds 40 per cent must be given. The infusion of a bicarbonate-glucose mixture intravenously combats metabolic acidosis and raises the pH but still does not deal with the central problem which is the disorder of gas exchange. Artificial ventilation may be of great importance, but use of respirators in premature infants is still technically difficult in most hospitals. What relation, if any, current research into the etiology of peripheral vascular collapse,[16, 17] into the nature of the alveolar lining layer,[14] and into other pathogenetic factors will have to treatment of this disorder, is a question answerable only in the future.

Summary

The respiratory distress syndrome (RDS) in a premature infant is presented together with the characteristic diagnostic criteria, roentgenologic appearance, clinical course, and pathologic findings of the lungs at postmortem ex-

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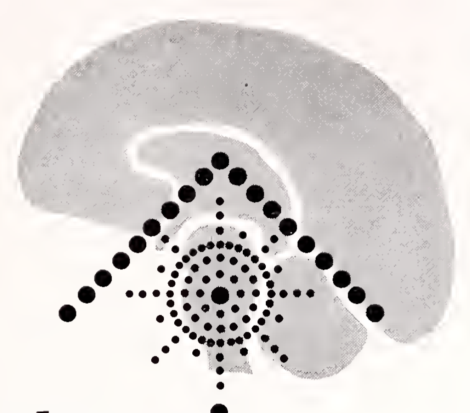

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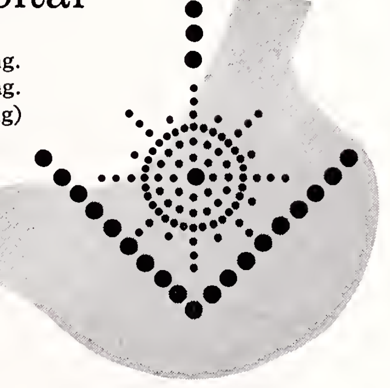
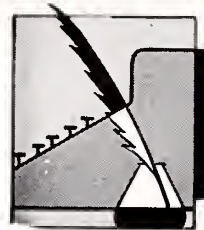
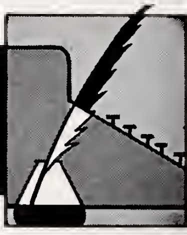




EDITORIALS



Our Problem is Common to All

EVERY year the staff of your Journal has an opportunity to convene at national or regional conferences with the editors and representatives of a large number of the State Medical Journals for consultation and exchange of ideas. This year the national bi-annual conference for state medical journal editors, sponsored by the State Medical Journal Advertising Bureau, was in Chicago during October. Mr. Joe Sanford had prepared the program and presided over the sessions. He was highly complimented by all present for the excellence of the material presented and the smooth conduct of the meeting.

Dr. Coe moderated a panel on the subject of "The Editor and His Contributors." Participating were Editors Dr. George H. Yeager of the Maryland Journal; Dr. R. H. Kampmeier of the Tennessee State Journal and Southern Medical Journal; Dr. A. Henry Claggett of the Delaware Journal; Dr. George W. Covey of the Nebraska Journal. Dr. Coe presented some of our own problems and conducted the panel exceedingly well. We have reason to be highly pleased with the contributions that these two members of our staff made toward the success of the meeting.

The theme of this convention was basically the improvement of medical care through the agency of the State Medical Journal, and most of the discussions were pointedly based upon this premise. Great emphasis is now placed upon continuing medical education and post graduate study. It was felt by all the physicians in attendance that a properly conducted Journal which carries to its members excellent scientific articles and discussions constitutes a strong force in upgrading medical practice.

It is only on selected occasions that a physician may leave his home and attend a post graduate course or seminar. The Journal comes to his desk every month and awaits a spare moment which may be available for reading. In the course of a year a very significant amount of information may be gathered from this source alone.

Many editors feel that the State Journal has much to offer that the National Journals lack. For one thing, the reader has an opportunity to know first-hand the author and the medical school, or institution from which he derives his information, and he is in far better position to evaluate the material presented than if he reads a contribution from some man about whom he knows little. Furthermore, the material presented in the State Journal is usually well adapted to the locality in which the members work.

State Medical Journals in recent years have been in financial difficulty of greater or less degree because of the rapid decline in advertising material available: it has been steady and even precipitous during the past four years. Many factors have brought about this change, none of which are within our power to alter at present. The journals have therefore been obliged to make some adjustment and fine new means of financial support. We learn that our Journal has had a somewhat less severe restriction in this regard than many of its sister publications. A considerable portion of the discussion dealt with this problem and the exploration of possible means of its solution.

The suggestion has been made in numerous areas that the State Medical Journal no longer has the appeal or the field of usefulness that it once enjoyed. It is certain that no enterprise remains static over a long period of time and changes must be made to meet present conditions. It has been proposed by various State Medical Society Boards of Trustees, Editors, and others interested, that less frequent publication of the Journal may be in order, perhaps bi-monthly or quarterly. Some have suggested the discontinuance of the State Journal as a medium of scientific information and its replacement by a simpler bulletin devoted to social and economic affairs and matters of general interest other than scientific. Regional journals in which several states combine their

efforts has been put forward as one solution. This has been a successful venture among several of the less populous Rocky Mountain states.

The opinion was firmly expressed by all of those attending the recent meeting that none of these proposals are appropriate at the present time. A State Medical Society without an official organ for its membership seems unthinkable to most physicians. The Journal is thought to be a strong element in the cohesive and cooperative qualities of State Medical Societies. It is felt by the Editors that the place of the State Journal cannot be taken by any other type of medical publication.

The matters under discussion have perplexed our own Society; they remain problems to which the perfect solution has not been found. You may be sure that your editorial staff will continue, with your cooperation, to make our Journal a valuable and effective instrument in the continued improvement of medical care in our state, and, we hope, a source of pleasure and pride.

Sam A. Overstreet, M.D.

The Doomed Dropouts

THE newspapers report of the progress being made in the field of education, we see a record number of school plants being constructed as we travel across our state, and our high school and college enrollment are booming, but how many of us stop to reason that we have an appalling number of youths who will never have an adequate education, or employment opportunity . . . or that a pot of social menace is in the brewing stage.

What we are discussing is the student who drops out of school because of multiple factors which are complex and inter-related. It is estimated that seven million youngsters will drop out of school in the next decade, an estimated 750,000 dropped out in 1962. In Kentucky, according to the U. S. Office of Education, 57.2 percent of the pupils who entered school in grade nine in 1958 graduated in 1962. 42.8% Kentucky pupils dropped out before graduation!

Many dropouts live their entire lives without ever having held a job. There are few employment opportunities for the dropout. They are usually the last to be hired and the first to be fired.

The average dropout has just turned 16 and probably is in the 10th grade, one year behind his group. He has enough aptitude to graduate from high school but probably is failing in one or more subjects. He is a poor reader, participates very little in extra-curricular school activities, and lives in substandard housing. Located in the poor section of a major city, his high school is a large one. Neither of his parents completed high school.

The problem of high school dropouts effects every community. Therefore, as a leader in your community, each physician has an obligation to remind every individual considering such a step of the difficulties and dangers he faces.

SPECIAL ARTICLES

Medical Events In Kentucky One Hundred Years Ago A Review Of The Year 1863

JOAN TITLEY*
Louisville, Ky.

January 1863

For the first time in the 26 year history of the *Medical Department of the University of Louisville* no class was graduated. This was due in part to the absence of two faculty members, Dr. D. W. Yandell and Dr. Bemiss.[1]

* * *

The *surgeons and nurses sent from Louisville* to Nashville on the first Saturday in January to care for the sick and wounded were the first delegation to leave Nashville after the battle of Stone River (Murfreesboro) on this errand of mercy; the news from General Rosecrans is still more bright and glorious.[2]

* * *

Dr. W. T. Owen of Louisville has published an article entitled "Premature Delivery with the Rare Presentation of the Foetus," in the January issue of the American Journal of the Medical Sciences, *45*:77-78, 1863.[3]

* * *

February 1863

The Board of Trustees of the University of Louisville in its meeting on February 17th authorized the *storing of tobacco* in the basement of the Medical College Building providing a reasonable compensation be offered.[4]

* * *

March 1863

It is with great regret that the death of *Dr. Charles W. Short* on 7 March is noted. Dr. Short, born October 6, 1793, was Professor of Materia Medica at Transylvania University Medical College and then at the University of Louisville Medical Department until his retirement in 1849.[5]

* Librarian and assistant professor of Medical Bibliography, School of Medicine, University of Louisville

April 1863

Dr. J. Lawrence Smith, Professor of Chemistry at the Medical Department of the University of Louisville has published an article entitled "Formula for a Solution of Bromine" in the April issue of the American Journal of the Medical Sciences, *45*:385-386, 1863.[6]

* * *

May 1863

The *military hospitals in Lexington, Kentucky* have been closed, and the patients transferred to the hospitals in Cincinnati and Camp Dennison. It is the intention of Dr. Church, the Medical Director, to send all sick and who can bear transportation to the above hospitals.[7]

* * *

June 1863

The *American Medical Association* held its first meeting in two years on June 2 at Chicago, Illinois. No delegates from the State of Kentucky attended.[8]

* * *

On June 19th the Board of Trustees of the University of Louisville elected *Dr. Lewis Rogers* to fill the Chair of Materia Medica and Medical Jurisprudence and *Dr. George Bayless* to the Chair of Physiology and Pathological Anatomy. It is hoped that with a complete faculty the Medical Department will resume graduating classes.[9]

* * *

The medical profession was greatly shocked to learn of the burning on June 22 of the *Transylvania College Medical Hall* which was used by the Government as a hospital. The loss is valued at $90,000 which must be borne by the Government. Happily the major portion of the museum and the 6,000 volume medical library were preserved. The conflagration ori-

ginated, it appeared, from a defective flue of a temporary frame kitchen, built adjoining.[10]

* * *

The Medical Department of the University of Louisville announces the resignation of *Dr. A. B. Cooke* as Demonstrator in Anatomy and the election of *Dr. Thomas P. Satterwhite* as his successor. *Mr. R. Ryan* has been elected Librarian for 1863-1864, his services to be rendered in exchange for his course of lectures. Dr. Benson, Professor of Anatomy, has been reelected Dean.[11]

* * *

July 1863

Surgeon R.M.S. Jackson, U.S.V. has been assigned to duties as Medical Director, 23d Army Corps, Lexington, Kentucky.[12]

* * *

August 1863

At a meeting of the Faculty of University of Louisville Medical Department *Drs. Benson and Smith* were appointed to devise means for the building and establishment of a *Dispensatory* on University grounds. They are also to look into the possibility of having *water* introduced through the building. Both will be great improvements in the facilities for medical education in this state.[13]

* * *

September 1863

Dr. M. Goldsmith, U.S.V. of the Government Hospitals of Louisville has published his *A Report on Hospital Gangrene, Erysiphelas and Psyaemia, as Observed in the Departments of the Ohio and the Cumberland with Cases Appended.* (Louisville, Bradley and Gilbert, 1863. 95 pp.)

November 1863

Professor Benson, Dean and Professor of Anatomy at the Medical Department of the University of Louisville was *arrested and thrown into Military Prison* on November 22. The Faculty fears he will be held some time—possibly the balance of the session. Dr. Bayless has been chosen Dean Pro-Tem and Dr. Palmer has reluctantly undertaken the delivery of the lectures on Anatomy as well as his own on surgery.[14]

* * *

December 1863

On December 5, Dr. T. S. Bell on behalf of the Medical Faculty of the University of Louisville is requested to write *Judge Advocate Holt* at Washington inducing him to *urge the President to parole Professor Benson,* Dean and Professor of Anatomy in the Medical Department until such time as Dr. Benson's trial should come up.[15]

* * *

Surgeon M. Goldsmith, U.S.V. has been ordered by Surgeon-General Hammond to visit the General Hospital at New York, Baltimore, Philadelphia and Washington with a view to collect material for his report on hospital gangrene which has so successfully been treated and reported by Surgeon Goldsmith in the hospitals at Louisville, Kentucky.[16]

* * *

The Medical Faculty of the University of Louisville Medical Department announced that *Professor T. S. Bell* will deliver the valedictory address to the medical graduates of the 1863/64 session. The Medical College holidays will be from December 23-27 with classes resuming promptly on the 28th. The faculty requests all students to pay heed to this announcement.[17]

* * *

An unfortunate occurrance in December resulted in the arrest of *Dr. Satterwhite,* Demonstrator of Anatomy at the Medical Department, *P. C. West,* a medical student, and the *janitor* of the college; these gentlemen having "*subjects*" in their possession. They have been indicted by the Grand Jury and will be tried the first Monday in January. The Medical Faculty has assured Dr. Satterwhite it will take care of any fines imposed upon Mr. West and the Janitor.[18]

References

1. Neither the Minutes of the University of Louisville Board of Trustees nor the Faculty of the Medical Department lists graduates nor do they mention why there were none.
2. Cincinnati Daily Gazette, January 7, 1863.
3. American Journal of Medical Sciences 45:77-78, January, 1863.
4. University of Louisville, Board of Trustees, Minutes [Manuscript] p.126.
5. [Obituary.] American Journal of Medical Sciences 45:535-536, December, 1863.
6. American Journal of Medical Sciences 45:385-386, April, 1863.
7. Cincinnati Lancet and Observer 6:317, June, 1863.
8. American Medical Associations. Transactions. 1863.
9. University of Louisville, Board of Trustees Minutes [Manuscript] p.128.
10. Peter, Robert. The History of the Medical Department of Transylvania. Louisville, J. P. Morton, 1905, pp.161-162.
11. University of Louisville, Medical Department. Minutes of the Faculty [Manuscript] p.59.
12. Cincinnati Lancet and Observer 6:453, July, 1863.
13. University of Louisville. Medical Department. Minutes of the Faculty, [Manuscript] p.61.
14. *Ibid.,* p.65.
15. *Ibid.,* p.67.
16. Cincinnati Lancet and Observer 6·754,December. 1863.
17. University of Louisville. Medical Department. Minutes of the Faculty [Manuscript] p.67.
18. *Ibid.*

ORGANIZATION SECTION

Doctor Clardy Chosen Pres-Elect at Annual Meeting

Delmas M. Clardy, M.D., Hopkinsville, was chosen president-elect of the Kentucky State Medical Association at the second session of the House of Delegates in Lexington on Wednesday evening, September 25. George P. Archer, M.D., Prestonsburg, was installed as president to succeed David M. Cox, M.D., Louisville.

Doctor Clardy

Doctor Clardy, a graduate of the University of Louisville School of Medicine in 1932, had served as KSMA treasurer since 1958. Keith P. Smith, M.D., Corbin, former chairman of the Board of Trustees, was elected treasurer to replace Doctor Clardy. When he was elected treasurer, Doctor Clardy had served as a KSMA delegate for 18 years and as a district councilor (now trustee)for six years.

A past president of the Christian County Medical Society, Doctor Clardy limits his practice to general surgery. He is president of the Kentucky Surgical Society, a fellow of the American College of Surgeons, and a member of the Southeastern Surgical Congress.

A native of Tennessee, he started in practice in 1934. In 1936 he established the surgery department at Western State Hospital. During his two years overseas, he was chief of the 187th General Hospital in England. He has served as chairman of the KSMA's public health committee for the past six years.

New vice presidents are: Carl C. Cooper, M.D., Bedford (Eastern); Carlisle Morse, M.D., Louisville (Central); and John Dickinson, M.D., Glasgow (Western).

Henry B. Asman, M.D., was elected to a three year term as secretary, succeeding Woodford B. Troutman, M.D., Louisville. Doctor Smith's term as treasurer is also for three years. The vice presidents, the president and the president-elect all serve for one year.

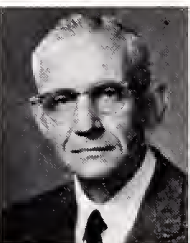
J. Thomas Giannini, Louisville, an alternate delegate was elected to fill the term of Robert C. Long, M.D., Louisville, as delegate to the AMA. Doctor Long resigned because of his recent election to the Board of Trustees of the AMA. Charles G. Bryant, M.D., Louisville, was elected alternate delegate, replacing Doctor Giannini. Their terms run from September 25, 1963 to December 31, 1964.

Wyatt Norvell, M.D., was re-elected AMA delegate. Charles C. Rutledge, M.D., was elected alternate delegate, to replace Doctor Cooper, who was elected a vice president. John C. Quertermous, M.D., Murray, was elected AMA delegate. He replaces J. Vernon Pace, M.D., Paducah. William W. Hall, M.D., was chosen as alternate to succeed Doctor Quertermous. Their terms will start on January 1, 1964.

Congratulating one another at the second session of the House of Delegates at the Annual Meeting are George P. Archer, M.D., 1963-64 KSMA president, and David M. Cox, M.D., 1962-63 president.

KSMA Board of Trustees Elects Drs. Scott and Payne

Douglas E. Scott, M.D., Lexington, was elected chairman of the KSMA Board of Trustees at a meeting of the Board at noon on Thursday, September 26 during the Annual Meeting in Lexington. Gabe A. Payne, Jr., M.D., Hopkinsville, was elected vice chairman.



Dr. Scott

Doctor Scott, trustee from the tenth district, follows Keith P. Smith, M.D., new KSMA treasurer, as chairman. Doctor Scott, a urologist, has served the Association in many capacities, most recently as chairman of the budget committee. Doctor Payne, trustee from the third district, replaces John P. Glenn, M.D., Russellville, whose term expired this year.

Elected as new trustees by the House of Delegates were: Alfred O. Miller, M.D., Louisville, Fifth Dis-

trict; Rex E. Hayes, M.D., Glasgow, Sixth; W. Donald Janney, M.D., Covington, Eighth; and Robert E. Pennington, M.D., London, Fifteenth. Donald Chatham, M.D., Shelbyville, Seventh District, and Hubert C. Jones, M.D., Berea, Eleventh, were re-elected.

Doctor Miller succeeds Carlisle Morse (new vice president); Doctor Hayes follows John P. Glenn, M.D., Russellville; Doctor Janney replaces Dexter Meyer, M.D., Covington; and Doctor Pennington succeeds Keith Smith, M.D., Corbin.

'KSMA Communicator' is Title Of New Newsletter

The "KSMA Communicator" will be the title of the new KSMA newsletter, which will take the place of the Secretary's Letter and Newscapsules.

The Communicator will be issued on an "as needed basis" and will not follow a set schedule. The combination of the two letters grew out of a recommendation by the Council on Communications and Public Service. The new letter will be signed by the KSMA Secretary.

Reasons for the combination were to save money and provide for more efficient communications with the membership at appropriate times.

The KSMA newsetters were issued monthly for 179 consecutive months, the last one being distributed in October, 1963.

MIXING BEAUTY AND BUSINESS—Guest speaker of the Woman's Auxiliary to the KSMA, Ever Curtis, M.D., Gloucester, Mass., left, poses with Mrs. James S. Rich, Lexington, 1962-63 Auxiliary president; Mrs. J. Murray Kinsman, Louisville, new president; and Mrs. J. Jack Martin, Tompkinsville, president-elect.

Mrs. Martin Named Pres.-Elect of Woman's Auxiliary

Mrs. J. Jack Martin, Tompkinsville, was named president-elect of the Woman's Auxiliary to the Kentucky State Medical Association at the September 25 business session of the Auxiliary's Annual Convention held in Lexington.

Mrs. J. Murray Kinsman of Louisville was installed as 1963-64 president, succeeding Mrs. James S. Rich, Lexington. The meeting was held September 24-26 at the Lafayette Hotel in conjunction with the KSMA Annual Meeting.

Other new officers and committee chairmen named were: Mrs. O. L. May, Danville, second vice-president; Mrs. Meyer H. Harrison, Louisville, corresponding secretary; Mrs. C. Melvin Bernhard, Louisville, parliamentarian; Mrs. Robert C. Long, Louisville, AMERF committee chairman.

Mrs. Jesse T. Funk, Bowling Green, was named benevolence chairman; Mrs. Barton L. Ramsey, Somerset, Bulletin chairman; Mrs. C. Melvin Bernhard, Louisville, by-laws chairman; Mrs. J. Andrew Bowen, Louisville, civil defense; Mrs. Charles F. Wilson, Pikeville, community service; Mrs. Stuart P. Hemphill, Danville, Doctor's Shop; Mrs. Hoyt D. Gardner, Louisville, health careers; Mrs. A. S. Holmes, Corbin, health careers co-chairman.

Other committee chairmen are: Mrs. Carl Shroat, Frankfort, heart; Mrs. J. L. Stambaugh, Lexington, legislation; Mrs. W. C. Cloyd, Richmond, legislation co-chairman; Mrs. R. Glenn Greene, Owensboro, mental health; Mrs. James S. Rich, Lexington, nominations; Mrs. George P. Archer, Prestonsburg, program; Mrs. Robert C. Tate, Louisville, publicity; Mrs. C. Dana Snyder, Hazard, rural health; and Mrs. William C. Durham, and Mrs. Robert B. Nolan, both of Louisville, convention chairmen.

Doctor Hendon To Head Ky. Diabetic Ass'n.

James R. Hendon, M.D., Louisville, was named president of the Kentucky Diabetic Association at the September 23 meeting of the Association held in Lexington.

Lewis Dickinson, M.D., Glasgow, and William W. Winternitz, M.D., Lexington, were elected vice presidents. Other officers named at the meeting were Kenneth Crawford M.D., Louisville, secretary, and Arthur T. Hurst, M.D., Louisville, Treasurer.

Doctor Hendon, who limits his practice to internal medicine, is a 1934 graduate of the University of Louisville. He replaces Robert S. Tillett, M.D., Louisville, last year's president.

Sixty-Six Participated In 1963 Golf Tournament

A record sixty-six physicians participated in the 1963 Kentucky State Medical Golf Association Tournament held at the Lexington Country Club during the week of the KSMA Annual Meeting — September 23-26.

Eugene Snowden, M.D., Winchester, and Robert McLeod, Jr., M.D., Somerset, were awarded trophies as co-champions of the tourney. Tied for low net were William H. McKenna, M.D., Mt. Sterling, Samuel O. Hodges, M.D., Lexington, and Henry F. DeLong, M.D., Louisville.

Kenton D. Leatherman, M.D., Louisville, was chairman of the Golf Committee and Marion G. Brown, M.D., Lexington served as co-chairman.

Doctor Leatherman and Doctor Brown announced the winners who also included: Senior Championship Trophy, Harold B. Graves, M.D., Louisville; and Senior Low Net Champion, K. D. Leatherman, M.D., Louisville. Nineteen of the sixty-six participants in the tournament received prizes other than the seven trophies that were awarded.

Distinguished Service Award Goes to Dr. Overstreet

Sam A. Overstreet, M.D., Louisville internist and editor of The Journal of KSMA, was the recipient of the 1963 KSMA Distinguished Service Award in recognition of his outstanding contributions to his profession.

The award was one was one of the three traditional presentations made at the President's Luncheon during the 1963 Annual Meeting of the Kentucky State Medical Association held September 24-26 in Lexington.

Doctor Overstreet, who was centennial president of the KSMA in 1951, has served organized medicine in many other capacities. He has been speaker of the KSMA House of Delegates and a member and chairman of numerous committees, past president of the Jefferson County Medical Society and a recent governor for Kentucky of the American College of Physicians.

Currently a Councilor for the Southern Medical Association and a member of the Kentucky State Board of Health, Doctor Overstreet is a clinical professor of medicine at the University of Louisville School of Medicine, where he received his M.D. in 1923.

Adam G. Osborne, M.D., 76, Pikeville, who received the Outstanding General Practitioner Award, began his practice in the mining camps of Virgie and Jenkins, Ky. shortly after being discharged from the U. S. Army Medical Corps of World War I.

A 1916 graduate of the U. of L. School of Medicine, Doctor Osborne has delivered more than 5,000 babies in his 47 years of practice. He was instrumental in the formation of the Pikeville Clinic and has served the Pike County Medical Society in all its offices. He has also been a member of the House of Delegates of the KSMA.

Robert G. Matheson, Ph.D., president of Paducah Junior College and a civic leader in his community, received this year's R. Haynes Barr Award. He was cited for his role in the establishment, in 1957, of the Paducah-McCracken County Health Association.

Doctor Matheson served three terms as president of the organization, and has continued to serve on the boards of the association and of the Mental Health Center in Paducah. He has also served as a psychologist for the Mental Health Center.

KSMA Representatives to Attend AMA Clinical Meet in Portland

Several Kentucky State Medical Association members have, at this writing, made plans to attend the 17th clinical meeting of the American Medical Association in Portland, Ore., December 1-4.

Among those going West for the winter session are the KSMA Delegates to the AMA: J. Vernon Pace, M.D., Paducah; Wyatt Norvell, M.D., New Castle; and J. Thomas Giannini, M.D., Louisville. Alternate Delegates are: John C. Quertermous, M.D., Murray; Carl C. Cooper, M.D., Bedford; and Charles G. Bryant, M.D., Louisville.

Robert C. Long, M.D., Louisville, a member of the AMA Board of Trustees, will also go to Portland for the meeting. Other Kentuckians in the party will include George P. Archer, M.D., Prestonsburg, KSMA president, and the president-elect, Delmas M. Clardy, M.D., Hopkinsville.

More than 7,000 physicians and their guests are

KSMA AWARD WINNERS at the 1963 Annual Meeting are, from left: Sam A. Overstreet, M.D., Louisville, Distinguished Service Medal, Robert G. Matheson, Ph.D., Paducah, R. Haynes Bar Award; and Adam G. Osborne, M.D., Pikeville, Outstanding General Practitioner Award. At right is William Bizot, M.D., Louisville, KSMA Awards Committee chairman, who made the presentations.

expected to gather in Portland for the first clinical meeting ever held there. Nearly all the scientific sessions, and all scientific and technical exhibits will be in the city's new multi-million dollar Memorial Coliseum.

Lectures, panels, symposia, and breakfast roundtables will be presented, as well as color television and medical motion pictures. More than 100 physicians will deliver lectures on the scientific program during the four-day meeting, and more than 200 scientific and industrial exhibits will be shown.

Dr. Norvell on AMA Committee

Wyatt Norvell, M.D., New Castle, KSMA Delegate to the AMA, was named to serve on a reference committee at the Portland winter clinical meeting of the AMA, December 1-4.

Milford O. Rouse, M.D., Dallas, Tex., Speaker of the House of Delegates, has appointed Doctor Norvell to serve on the Reference Committee on Legislation and Public Relations.

KSMA House Votes Dues Increase Effective Jan., 1964

Among the more important actions of the 1963 KSMA House of Delegates was a vote to increase the Association's annual dues from $50 to $75. effective January 1, 1964.

A special report of the Board of Trustees was presented by Douglas Scott, M.D., Lexington, chairman of the Board. The report pointed out that the increase was necessary because of expanded programs authorized by the House of Delegates and other KSMA bodies and because revenue from the Journal had decreased as a result of restrictive drug laws passed in 1962.

When the special committee was studying the need for increased revenue, it polled other state medical associations to learn what their 1963 dues were. The following information was developed as a result of this poll.

State	Amount of Active Dues	State	Amount of Active Dues
Alabama	$ 50	Montana	$ 65
Alaska	75	Nebraska	45
Arizona	105	Nevada	120
Arkansas	45	New Hampshire	60
California	75	New Jersey	40
Colorado	70	New Mexico	90
Connecticut	40	New York	45
Wash. D. C.	70	N. Carolina	60
Delaware	80	N. Dakota	100
Florida	50	Ohio	35
Georgia	40	Oklahoma	47
Hawaii	66	Oregon	60
Idaho	100	Pennsylvania	60
Illinois	80	Rhode Island	60
Indiana	55	S. Carolina	35
Iowa	90	S. Dakota	100
Kansas	50	Tennessee	40
Kentucky	50	Texas	45
Louisiana	50	Utah	85
Maine	55	Vermont	65
Maryland	50	Virginia	40
Massachusetts	35	Washington	60
Michigan	80	W. Virginia	50
Minnesota	75	Wisconsin	90
Mississippi	50	Wyoming	50
Missouri	42.50		

KSMA president David M. Cox, M.D., reacts to one of the jokes of the popular President's Luncheon speaker, Henry M. Johnson, D.D., Indianapolis, on September 25 during the Annual Meeting.

Dr. Johnson Says Medicare Indicates Lack of Spine

The concept of Medicare indicates a lack of backbone on the part of America as a nation, according to Henry M. Johnson, D.D., Ph.D., Indianapolis, featured guest speaker at the President's Luncheon held during the KSMA Annual Meeting in Lexington.

Doctor Johnson addressed Kentucky physicians and their guests on "How to Keep From Going Nuts in a Nutty World," in the Gold Room of the Lafayette Hotel on September 25.

Americans, said Doctor Johnson, have begun to expect too much assistance from the federal government. He warned that "if we can't learn to stand on our own two feet. some stronger nation will teach us."

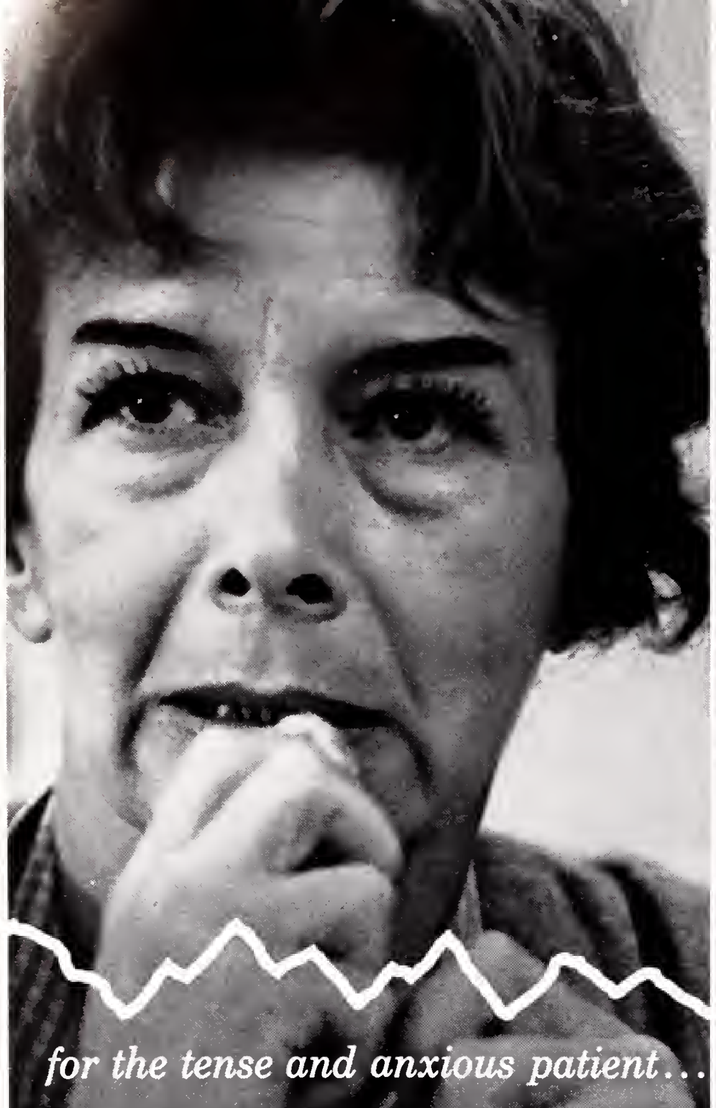
The widely-known lecturer prescribed a healthy balance of work and relaxation as a means of preventing mental distress. "Where did we get this idea that work is a curse?" he asked. "We should all develop a healthy attitude toward our jobs."

He pointed out that one of every ten Americans is suffering from a mental disorder of some kind, and that more are suffering from mental illness than from cancer, tuberculosis, heart disease, and all other major diseases combined.

Doctor Johnson maintained, however, that an intelligent escape from work is necessary in order to achieve a healthy balance. "Go nuts over a hobby," he advised. "Spectatoritis is a national disease," he said, urging active participation in sports and hobbies within the limits of common sense, rather than mere passive interest.

Kyians Attend Heart Meeting

William R. Bushong, M.D., Tompkinsville, president of the Kentucky Heart Association, is one of three Kentucky physicians who attended the 1963 Annual Meeting of the American Heart Association October 27-29 in Los Angeles. Also representing the KHA were George W. Pedigo, Jr., M.D., Louisville, and Frank Spencer, M.D., Lexington.



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Side Effects: Rarely, skin reactions. May increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence in patients with history of drug or alcohol addiction.

Available: *'Meprospan'-400* (meprobamate, sustained release) contains meprobamate 400 mg. *'Meprospan'-200* (meprobamate, sustained release) contains meprobamate 200 mg. Both potencies in bottles of 30. **Usual dosage:** One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

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CONCENTRATION on the business of the Association is demonstrated by the members of the House of Delegates during the opening session September 23 at the KSMA Annual Meeting at the Phoenix Hotel in Lexington.

House of Delegates Meets in Lexington During Annual Meeting; Considers Important Resolutions in Busy Sessions

For the first time in recent years, a morning meeting was held by the KSMA House of Delegates in regular session during the Annual Meeting.

The first session started at 9:00 Monday morning, September 23 and the final session was held Wednesday evening, September 26. Reference committees met Monday afternoon following the opening session, and officials of the association expressed their approval of the new system.

In more important actions, the House voted to discontinue the Committee on Continuing Medical Education. The Council on Medical Education and Hospitals will take over the matters that may arise in that area.

The House accepted a recommendation from the Council on Communications and Public Service to institute a program of mandatory indoctrination for new members. Final plans will be developed by this Council for this program.

The December issue of The Journal of KSMA will carry the complete minutes of the KSMA House of Delegates meeting and will include all reports, resolutions, recommendations, and final actions of the House.

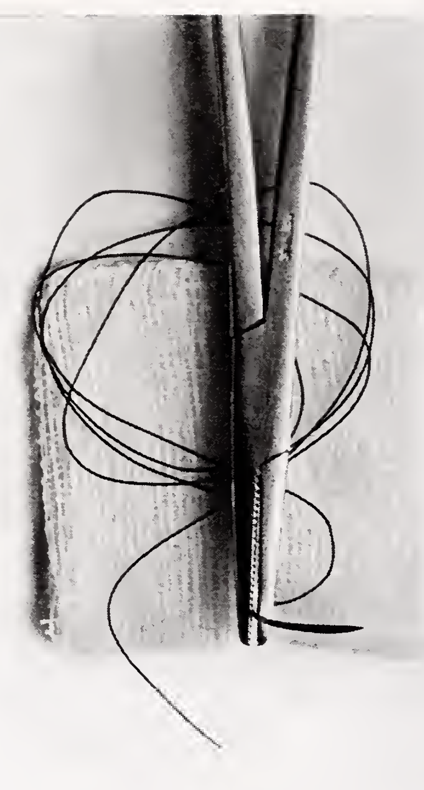
The House of Delegates refused to approve the proposal from the KSMA Committee on Membership and Placement to have an annual free licensure registration.

A recommendation from the Bylaws Committee proposed the deletion of the word "state" from the name of the Kentucky State Medical Association. This recommendation was accepted, and since it involves a change in the Constitution, it will lay over until the 1964 meeting for final action. In other actions taken by the House, it approved the holding of a dinner honoring Kentucky's Congressmen in Washington again in 1964, applauded the KSMA hospital committee on its excellent work and acted on a number of resolutions.

COMPARATIVE REGISTRATION FIGURES

KSMA Annual Meetings

	Louisville 1954	Louisville 1955	Louisville 1956	Louisville 1957	Louisville 1958	Louisville 1959	Louisville 1960	Louisville 1961	Louisville 1962	Lexngton 1963
KSMA Members	924	938	923	1094	971	997	1021	996	1014	865
Guest Physicians	150	122	157	178	166	165	203	194	208	141
Interns-Residents	148	106	105	142	108	128	105	102	102	69
Medical Students	284	299	305	328	269	280	289	237	176	59
Registered Nurses	25	55	15	28	22	34	25	31	59	31
Exhibitors	174	174	218	176	211	200	239	204	232	212
Guests	166	121	108	151	164	86	99	132	123	132
Technicians—Office Assistants	67	50	54	54	45	63	33	57	71	22
TOTAL ATTENDANCE	1938	1865	1885	2151	1956	1953	2014	1953	1985	1531



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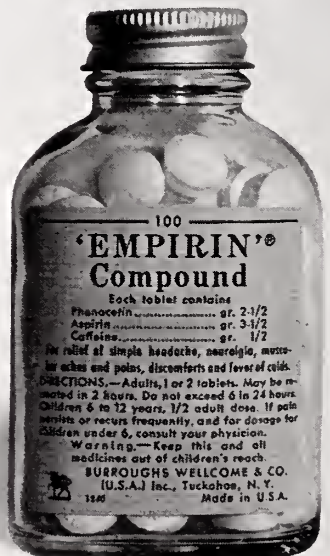

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gr. ⅛—No. 1/gr. ¼—No. 2/gr. ½—No. 3/gr. 1—No. 4
*Warning—may be habit forming

The Kentucky Educational Medical Political Action Committee featured Kentucky's two gubernatorial candidates as speakers at the dinner meeting ending the political seminar sponsored by KEMPAC Thursday afternoon and evening, September 26 following the KSMA Annual Meeting in Lexington. Left toright are Edward T. (Ned) Breathitt, Hopkinsville Democrat; George P. Archer, M.D., Prestonsburg, KSMA president; Louie B. Nunn, Republican candidate from Glasgow; and Hoyt D. Gardner, M.D., chairman of the KEMPAC Board.

AMPAC Official Addresses Political Seminar

B. J. Henningsgaard, M.D., Astoria, Ore., a member of the Board of Directors of the American Medical Political Action Committee, was the principal speaker at the political seminar held Thursday. September 26, in Lexington following the KSMA Annual Meeting.

The seminar and banquet which followed were sponsored by KEMPAC (Kentucky Educational Medical Political Action Committee), for the purpose of indoctrinating Kentucky physicians and their wives on politics at precinct, county and state levels.

A capacity crowd attended the banquet that evening in the Gold Room of the Lafayette. Featured guest speakers were Edward T. Breathitt and Louis B. Nunn, party nominees for the office of Governor of Kentucky.

Also participating in the afternoon program were precinct, county, and state campaign officials of both major political parties, who took part in a general discussion on political affairs.

KEMPAC is a bi-partisan organization made up of Kentucky physicians, whose aims are to elect the best possible candidates to all political offices, regardless of party. The primary objective is the attainment of the best and most representative type of government from a well-informed and interested electorate.

John P. Walton, M.D., who for many years has practiced in Central City, has sent word to his patients of his retirement. Doctor Walton graduated in 1906 from the Hospital College of Medicine in Louisville.

Vance Surgical Library Dedicated at U. K.

The University of Kentucky department of Surgery has formally dedicated its Vance Memorial Surgical Library in honor of the late Charles A. Vance, M.D., noted Lexington surgeon.

Doctor Vance

Volumes and journals owned by Doctor Vance and donated to the University by his family, are included in the library's collection. Contributions made in his name will be used to equip the two rooms set aside for the library, as well as to purchase additional literature for the collection.

Doctor Vance, who died in 1962, was a former president of the Kentucky State Medical Association and of the Fayette County Medical Society. He was a graduate of the University of Louisville School of Medicine.

Chest Physicians Elect Dr. Mayer

Lloyd D. Mayer, M.D., was named new president of the Kentucky Chapter of the American College of Chest Physicians at the September 26 luncheon meeting during KSMA annual meeting in Lexington. Armond Gordon, M.D., Louisville, was elected vice president of the group. "Right Heart Bypass" was the topic of the scientific address given during the meeting by Paul Sanger, M.D., Charlotte, N. Car.

U of L Medical Alumni Honor Doctor Murray Kinsman

J. Murray Kinsman, M.D., and Mrs. Kinsman were honored by nearly 500 alumni of the University of Louisville School of Medicine at the annual alumni cocktail party and dinner at the Lafayette Hotel, Lexington, on September 24.

Doctor Kinsman, who retired as Dean of the U of L School of Medicine in July to become a vice president of the University, was given a gold pen and pencil set and Mrs. Kinsman a silver tray. A portrait of Doctor Kinsman was presented to the medical school by the alumni in his honor.

The annual dinner, which is a traditional adjunct of the KSMA Annual Meeting, was also in honor of the classes of 1913, 1918, 1923, 1928, 1933, 1938, 1943, 1948, 1953, and 1958. Hoyt D. Gardner, M.D., Louisville, President of the Alumni Association presided.

Doctor Philip Davidson, U of L president, gave greetings from the University to the alumni. Featured speaker was Hugh Hussey, M.D., director of science activities of the AMA, who spoke on the increasing opportunities to spread scientific knowledge. Walter Coe, M.D., 1964 President-elect of U of L medical alumni, recognized reunion classes and department heads.

Alumni of University of Louisville Hospitals had previously honored Doctor Kinsman with a dinner. A medical student loan fund to be called the J. Murray Kinsman Loan Fund was established in his honor by the Board of Trustees of the U of L. He and Mrs. Kinsman were also honored by the Board and the Davidsons with a reception and gifts. At the last convocation of the school year the medical school student body gave him an award for distinguished service.

Doctor Kinsman was Dean of the Medical School for 14 years and has been a member of the active faculty in the department of medicine since 1925.

'64 Nominating Committee Elected

Names of the five men elected to serve on the Nominating Committee for the 1964 Annual Meeting were announced by the Speaker of the KSMA House of Delegates Garnett J. Sweeney, M.D., Liberty, following their election on September 25.

Chosen from a list of ten names at the second session of the House of Delegates were: C. Melvin Bernhard, M.D., Louisville; N. L. Bosworth, M.D., Lexington; Richard E. Davis, M.D., Central City; Paul F. Maddox, M.D., Campton; and J. Sankey Williams, M.D., Nicholasville. A chairman will be elected at the 1964 Interim Meeting.

Dr. O'Donoghue Installed

John B. O'Donoghue, M.D., Chicago, was installed as president of the United States Section of the International College of Surgeons in a ceremony during the September 1963 meeting of the executive council of the Section.

Books by Dr. Horine Chosen for White House Library

Emmet Field Horine, M.D., KSMA's official historian, is among the carefully chosen authors whose books have been selected for the White House Library.

Doctor Horine

Books for inclusion in the library were selected by a committee headed by Doctor James T. Babb, librarian at Yale University. The select list includes 1780 titles in approximately 2600 volumes. Books have been chosen in 32 categories which they have chosen to call chapters.

In "Chapter IV, Biography and Autobiography," is Daniel Drake, M.D., *Pioneer Life in Kentucky*, H. Schuman, 1948, which Doctor Horine edited and for which he wrote an introduction. "Chapter XVIII, Medicine and Public Health," contains Doctor Horine's definitive biography of Doctor Drake, *Daniel Drake (1785-1852), Pioneer Physician of the Midwest*, University of Pennsylvania Press, 1961.

1964 KSMA Annual Meeting Date Set for Sept. 29, 30, & Oct. 1

Date of the 1964 KSMA Annual Meeting was changed to September 29, 30 and October 1 from September 22, 23 and 24 by the Board of Trustees at the 1963 reorganizational meeting of the Board.

The Board took this action in order to free hotel space that week in Louisville for a convention somewhat larger than our own. This was the only date that the city could obtain this important meeting, said Douglas E. Scott, M.D., chairman of the Board of Trustees.

The 1964 meeting will be held at the new Convention Center (formerly known as the Jefferson County Armory). President George P. Archer, M.D., Prestonsburg, and members of the Council on Scientific Assembly met October 16 and made preliminary plans for the 1964 session.

The Convention Center was inspected by the Council, and Doctor Archer said he felt that the facilities would provide an excellent meeting place for KSMA.

EEN&T President Installed

Charles L. Bloch, M.D., Louisville, was installed as 1964 president of the Kentucky EEN&T Society at the September 26 business meeting of the society in Lexington.

Alvin C. Poweleit, M.D., Covington, was named president-elect for the coming year, and Edward C. Shrader, M.D., Louisville, was elected secretary-treasurer.

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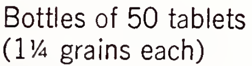

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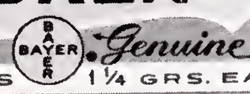

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Appalachian Regional Hospitals, Inc., Announce Policies On Staffing and Offices in Hospitals

The initial policies for the medical staffing and use of hospitals operated by the Appalachian Regional Hospitals, Inc., were announced following a meeting of the corporation's Board of Trustees, September 26, 1963. The policies went into effect October 1 when ARHI took title to the five hospitals in Harlan, Hazard, McDowell, Middlesboro, and Whitesburg built and operated by the Miners Memorial Hospital Association. Five additional hospitals in Kentucky, Virginia, and West Virginia may be transferred to ARHI July 1, 1964.

Members of the ARHI Board include Mr. Maxwell Barrett, Hazard; Mrs. Harry M. Caudill, Whitesburg; The Honorable Bert T. Combs, Frankfort, Kentucky; Mr. Maurice Henry, Middlesboro; Dr. David K. Heydinger, Columbus, Ohio; The Honorable Edward Hill, Harlan; Dr. D. Allen Locke, Board of National Admissions, United Presbyterian Church, New York, New York; Mr. Robert C. Millar, Minneapolis, Minnesota; Dr. James A. Moak, Lexington; Dr. Kenneth G. Neigh, Board of National Admissions United Presbyterian Church, New York, New York; and Mr. Lon B. Rogers, Pikeville. This 30-member board will eventually be completed with representatives from the communities in which the hospitals are located, and with individuals of national scope.

James B. Holloway, M.D., Lexington, chairman of the KSMA Hospital Committee, represented the Association at the ARHI Board of Trustees meeting and noted that the action taken was initiated by the Board members from Eastern Kentucky, and the lead of the Eastern Kentuckians was followed in all matters. He also noted that local advisory committees to the ARHI Board are now being formed.

The Board reported that time did not allow for an orderly and thorough re-evaluation of the credentials of all the physicians who had served up to this time on the staffs of the several UMWA hospitals.

In keeping with the policy of the ARHI that the hospitals shall be operated in the interests of and for the benefit of the total communities, and at the same time establishing the highest possible quality of services, the SRHI Board has approved the following procedures for implementation:

Staffing

(1) All physicians who have held staff appointments under the MMHA operation shall be retained on the staff in their present categories, if they so desire, without submission of new applications or reviewing of credentials for the period October 1, 1963 through June 30, 1964.

(2) The physicians included under this blanket staff appointment procedure and other appointed under paragraph four below shall develop a medical staff organization during the period October 1, 1963 through June 30, 1964. Rules and regulations, committee assignments, etc., shall be established by these doctors under the guidance and direction of the executive director of the ARHI, whose appointment will be announced shortly. All physicians remaining on the staffs and holding positions as chiefs of departments or services shall retain these positions pro tem until new appointments can be made by the ARHI Board under (3) below.

(3) It is intended that all the active staff physicians in the several hospitals shall constitute one regional staff for the purposes of coordination of specialty services, consultations, and utilization of facilities. However, the active staff physicians working in the individual hospitals shall, in addition, organize themselves into an internal or local hospital staff. These local staffs shall establish necessary committee structures for supervision and development of services and patient care. The over-all regional staff organization for the several hospitals shall not include chiefs of departments or services except insofar as these may be necessary to cover more than one hospital as, for example, in the case of pathology or radiology where one or a group of pathologists or radiologists provide services to more than one hospital. However, where there are qualified surgeons, internists, pediatricians, or obstetricians, etc., in the individual hospitals the supervision of the clinical activities of the staffs located in these hospitals shall be undertaken by the local specialists as chief of departments or services.

The regional staff organization shall be primarily administrative and standard-setting, and developed for the purpose of recommending policy to the Board of Trustees, and for coordinating the work of the several hospitals. From time to time, this policy will be re-evaluated by the Board as more physicians migrate into the region and enter either solo practice or join group practice.

(4) In the course of the period October 1, 1963, through October 15, 1963, through the evaluations to be made by a pro tem credentials committee of each of the individual hospitals (consisting of members of the present staff) and from recommendations to be made by such committees to a credentials committee of the Regional Hospital staff, the ARHI Board shall make additional staff appointments after July 1, 1964, for the period July 1, 1964-June 30, 1965. Doctors in the community who are not now on the staff(s) who may apply for appointment after October 1, 1963, will be evaluated as soon as possible after the pro tem credentials committees have been elected and, if appointed will be subject to reappointment on July 1, 1964. The decision by the Board in respect to the existing staff is not in any way a blanket commitment to permanent appointment of any physician who is presently on the staff(s) of the hospitals, either in solo practice or in group practice. Appointments shall be in keeping with the policy governing appointments of staffs of voluntary hospitals and shall be in accordance with the recommendations of the commission on Accreditations; namely,

that appointments are for one year and subject to review and renewal on a year to year basis.

Offices in Hospitals

In adopting policies as pertains to doctors' offices, the Board took into consideration the circumstances existing in the communities where the several hospitals being reorganized are located, the necessity of retaining as many doctors of the ex-UMWA group as possible, the development of coordination between all the doctors who will be working on the staffs of the hospitals and the need on the part of the ARHI to make these hospitals viable in they are to serve the communities in which they exist. The following policies were adopted:

(1) Until such time as plans can be drawn and capital secured for the construction of doctors' office buildings on, at, or near the hospitals, the Medical Group Associates will be privileged to rent space in the ambulatory patient areas of the hospitals. Other staff doctors may lease any additional space not leased by the Medical Group Associates.

(2) When plans have been drawn and capital secured for the construction of doctors' office buildings, doctors in the community, including the Group, shall be privileged to rent such space on a first come, first served basis.

(3) When the doctors' buildings are constructed, the space in the hospital being rented in the interim will be re-evaluated and reconstructed for:

(a) Additional diagnostic laboratory, administrative or treatment services as needed, or

(b) Outpatient clinic areas for the medically indigent, or

(c) Inpatient nursing units should these be desired.

(4) The ARHI Board of Trustees will make every effort to put this program into effect just as quickly as resources and personnel can be organized for the purpose, should the need for this development continue.

(5) The Board of Trustees of the ARHI invites inquiries and participation by all physicians in the utilization of existing space and in the programs for the development of office space as outlined above in separate office buildings.

Although no date has been set for doctors' offices to be removed from the five hospitals, the physicians now occupying offices in the Hazard Hospital are making arrangements to move to offices outside the hospital prior to January 1, 1964.

The Appalachian Regional Hospitals, Inc., according to ARHI President Kenneth G. Neigh, is purchasing the business services, accounting, statistics, purchasing, maintenance, etc., for over-all economy reasons for the time being, from the Miners Memorial Hospital Association. Doctor Neigh stated that it became apparent that setting up procedures for these services and securing personnel to carry on these operations would be extremely difficult if not impossible in the time that was available. It is anticipated that ARHI will take over these services entirely when it acquires the second five hospitals from MMHA, as scheduled on July 1, 1964.

Doctor Klicka Heads Appalachian Regional Hospitals, Inc.

Karl S. Klicka, M.D., Chicago, has been elected Executive Director of the Appalachian Regional Hospitals, Inc., by the corporation trustees. Doctor Klicka has been Executive Director of the Hospital Planning Council for metropolitan Chicago since 1959. He will assume his new assignment in Kentucky December 1 and will locate his headquarters office in Lexington.

Doctor Klicka

A native of Pennsylvania, Doctor Klicka is a graduate of Allegheny College and Western Reserve University Medical School. He received his Master of Hospital Administration degree from the University of Chicago, School of Business Administration.

Having always been interested in planning for health services on a community-wide basis, he has been in hospital administration since 1940. He has written more than thirty professional papers and holds membership in many professional organizations.

Doctors Schwert and Taylor Receive Faculty Awards

John F. Taylor, Ph.D., professor and chairman of the department of Biochemistry at the University of Louisville School of Medicine, and George W. Schwert, Ph.D., professor and chairman of the department of Biochemistry at the University of Kentucky College of Medicine, were the recipients of the 1963 KSMA Faculty Scientific Awards.

The awards, presented this year by David M. Cox, M.D., Louisville, president of KSMA, during the 1963 Annual Meeting in Lexington, were established in 1962 for the purpose of recognizing faculty members of Kentucky's two medical schools for outstanding research or other significant contributions.

Doctor Schwert joined the planning group at the University of Kentucky in 1959. He was recognized for his leading part in planning the curriculum at the College of Medicine, recruiting outstanding faculty members, and for his development of a strong department of Biochemistry.

Doctor Taylor, who has been with the University of Louisville for 11 years, was cited for his work in the development of the new curriculum which went into effect this fall. He was also honored because of the fine operation of his department and particularly his outstanding teaching program.

"Examination of the Stomach and Duodenal Bulb with the Fiberscope" received the Scientific Exhibits Award. The exhibit was prepared by F. Norman Vickers, M.D., Thomas R. Marshall, M.D., and Samuel H. Cheng, M.D., all of the University of Louisville School of Medicine.

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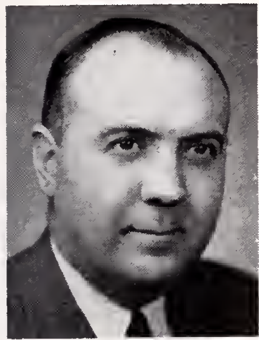
Farm Bureau Stand on King Anderson (HR 3920) Proposal Explained at Ninth KSMA Trustee District Meeting

More than 115 physicians, Farm Bureau members and public officials and their wives attended the Ninth KSMA Trustee District at Maysville, October 10, according to Mitchel B. Denham, M.D., Trustee for the district. On the afternoon preceeding the meeting a seminar was sponsored for the area by the Kentucky Academy of General Practice. It was reported that excellent papers were presented at that time.



Mr. Fleming

Roger Fleming, Secretary and Treasurer of the American Farm Bureau Association, and head of that organization's Washington Office, presented the address of the evening. Fleming said, "By their opposition to government medicine, Farm Bureau members have demonstrated again that they have not succumbed to the delusion that there is some magical way by which the national government can solve the essentially personal problems of its citizens."

Mr. Fleming said the total price tag for putting our government in "political medicine business" was too high. More important, however, he said, "More vital is the risk of individual freedom."

"Those schemes," he said, "simply are foot-in-the-door propositions which, if adopted, would be expanded to larger and larger groups of citizens and ultimately would lead to some form of socialized medicine." He pointed out that Farm Bureau members have been especially conscious of the problems in the field of medical care, and that they have been in the forefront of those supporting voluntary, pre-paid insurance plans.

"Let us not forget," he went on, "that here in the United States we have the best hospitals, nursing and medical care of any country in the world. This has been possible under a free choice system. Before we launch out on a system of socialized medical care we should carefully examine what has happened in other countries that have taken this route."

He outlined the chief reasons for the opposition of Farm Bureau members to legislation providing for compulsory health insurance:

1. It would transfer to an already over-centralized, over-obligated central government responsibilities that can and should be dealt with in other and better ways.

2. Financing medical care for the aged through the mechanism of social security would not provide "pre-paid insurance" in the usual meaning of the term, but would compel workers, employers and the self-employed to pay taxes to purchase health care benefits for those persons over 65 years of age, whether or not they are in financial need.

3. Enactment of compulsory medical care for the aged would lead to federal control because in this instance the individual would not receive the payments, but rather, the central government itself would make out a check for the "services" to a hospital or other institution.

4. The proposed program probably would soon spread to other age groups.

5. The medical care plan for the aged would be very costly, and costs would increase sharply, probably resulting eventually in the payment by many individuals of more in social security than in federal income taxes.

6. The need for medical care for the aged is not merely as great as it is pictured by its proponents.

7. Maintenance of today's high quality of medical care would be jeopardized.

8. Last, but not least, adoption of the proposal would lead to the decline, if not the death, of private health insurance.

Fleming added:

"The issue of government paternalism and control on the one hand versus individual responsibility and freedom on the other, is indivisible. That's why we in the Farm Bureau, representing the farmers and ranchers of this country, have a very square-toed position with regard to government medicine—whether you call it 'Medicare', 'Fedicare', 'Government Health Insurance'—which it isn't—or what not. We don't merely take the approach of recognizing that doctors and others on the 'health team' are against it. We have conviction in our own right—based upon our firm belief that this is one of the 'showdown points' in the broader and more fundamental question of the proper relationship between government and people."

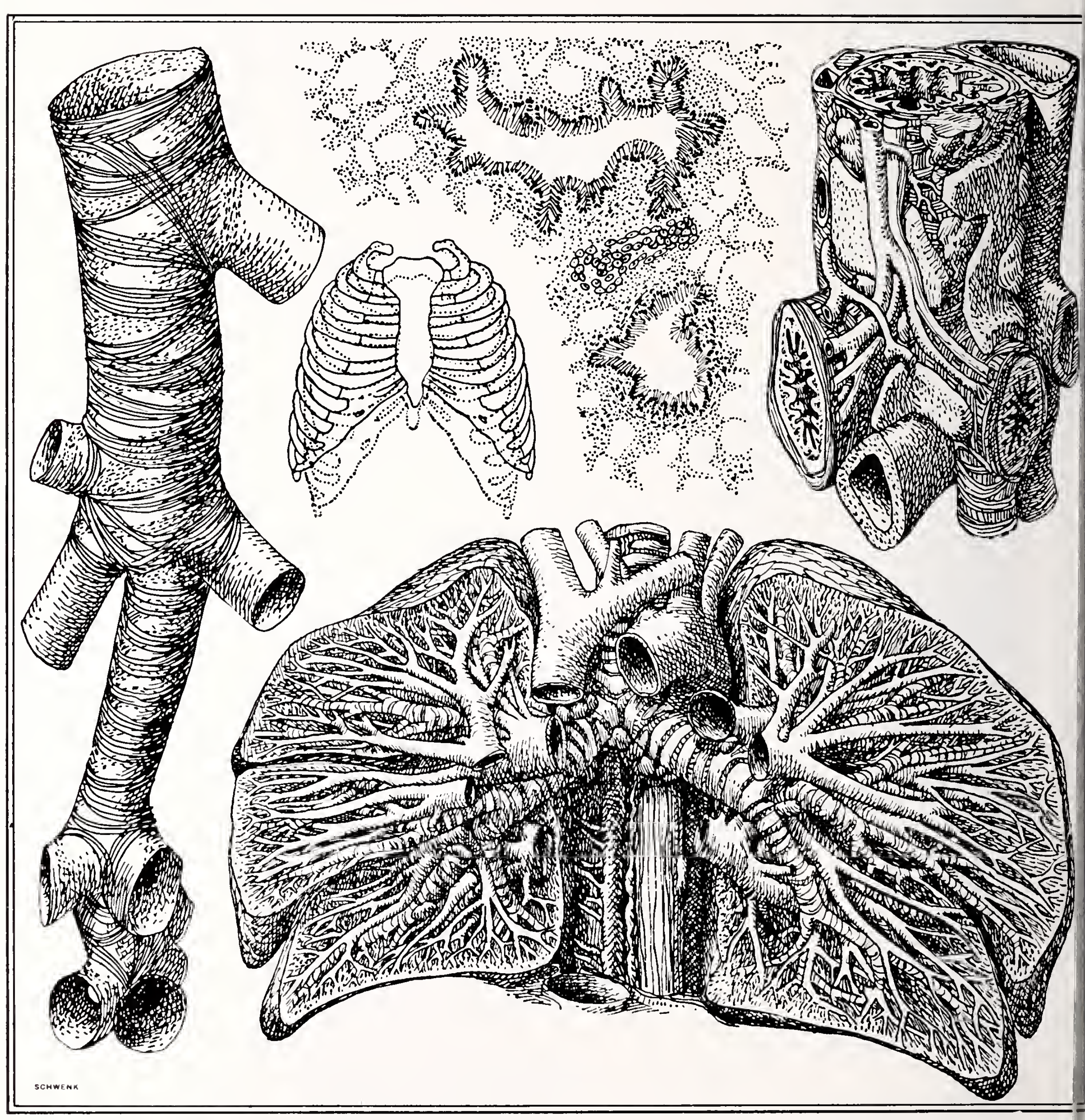
Public Health Group Elects

Edward M. Thompson, M.D., director of local health for the State Health Department, was elected president of the Kentucky Association of Public Health Physicians at a meeting of the group during the KSMA annual session in Lexington on September 26.

Other new officers include: C. E. Hernandez, M.D., Elizabethtown, president-elect; Russell L. Hall, M.D., Prestonsburg, vice president; and A. S. Holmes, M.D., Williamsburg, secretary-treasurer. B. F. Brown, M.D., Frankfort, was elected to a four-year term on the Board of Trustees and Russell E. Teague, M.D., Frankfort, was elected to the Board to fill the unexpired term vacated by Dillard Turner, M.D., Marion.

Dr. Teague Given Health Post

Russell E. Teague, M. D., commissioner of health of Kentucky, was elected for a three year term on the executive committee of the Association of State and Territorial Officers. Doctor Teague was named to the committee during the recent meeting of the group in Washington.



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Was Your Delegate Present?

ROLL CALL—
1963 House of Delegates*
KSMA Annual Meeting

OFFICERS

		First Session	Second Session
Speaker	Garnett J. Sweeney	Present	Present
Vice-Speaker	George F. Brockman	Present	Present
President	David M. Cox	Present	Present
President-Elect	George P. Archer	Present	Present
Vice-President	Alfred O. Miller	.....	Present
Vice-President	Hugh Mahaffey	Present	.....
Vice-President	Joseph R. Miller	Present	.....
Secretary	Woodford B. Troutman	Present	Present
Treasurer	Delmas M. Clardy	Present	Present
Delegate to the AMA	Robert C. Long	.....	Present
Delegate to the AMA	J. Vernon Pace	Present	.....
Delegate to the AMA	Wyatt Norvell	Present	Present
Alternate Delegate to the AMA	J. Thomas Giannini	Present	Present
Alternate Delegate to the AMA	John C. Quertermous	Present	Present
Alternate Delegate to the AMA	Carl C. Cooper	.....	.....

TRUSTEES

District			
First	O. Leon Higdon	Present	Present
Second	Howell J. Davis	.....	.....
Third	Gabe A. Payne	Present	Present
Fourth	Dixie E. Snider	.....	.....
Fifth	Carlisle Morse	Present	Present
Sixth	John P. Glenn	Present	.....
Seventh	Donald Chatham	.....	Present
Eighth	Dexter Meyer	.....	.....
Ninth	Mitchel B. Denham	.....	.....
Tenth	Douglas E. Scott	Present	Present
Eleventh	Hubert C. Jones	Present	.....
Twelfth	Thomas O. Meredith	Present	Present
Thirteenth	Clyde C. Sparks	Present	Present
Fourteenth	William C. Hambley	Present	Present
Fifteenth	Keith P. Smith	Present	Present

PAST PRESIDENTS

Past-President	Gaithel L. Simpson	Present	.....
Past-President	R. G. Elliott (deceased)		
Past-President	Irvin Abell, Jr.	.....	Present
Past-President	R. W. Robertson	.....	.....
Past-President	Edward B. Mersch	.....	.....
Past-President	Richard R. Slucher	.....	.....

DELEGATES

First District

County		First Session	Second Session
BALLARD	Jesse M. Hunt, Jr.	.....	.....
CALLOWAY	Hugh L. Houston	Present	Present
CARLISLE	John T. O'Neill	Present	Present
FULTON	Robert T. Peterson	.....	.....
GRAVES	John Reed	Present	Present
HICKMAN	V. A. Jackson	.....	.....
LIVINGSTON			
McCRACKEN	R. M. Wooldridge	Present	Present
	W. E. Sloan	.....	.....
	G. H. Widener	Present	Present
MARSHALL	J. R. Miller	Present	Present

Second District

County		First Session	Second Session
DAVIESS	L. C. Dodson	.....	Present
	W. H. Hall	Present	Present
	B. H. Warren	Present	Present
HANCOCK	B. Presley Smith	.....	.....
HENDERSON	Kenneth M. Eblen	Present	Present
McLEAN	W. G. Edds	.....	.....
OHIO	Oscar Allen	Present	Present
UNION	Wallace N. Bell	.....	.....
WEBSTER	Earl Atherton	Present	Present

Third District

County		First Session	Second Session
CALDWELL	N. H. Talley	.....	.....
CHRISTIAN	Guinn S. Cost	Present	Present
	Norma T. Shepherd	Present	Present
CRITTENDEN	R. M. Brandon	.....	.....
HOPKINS	Loman C. Trover	Present	.....
	Duane N. Tweeddale (Alter.)	.....	Present
	F. A. Scott	Present	Present
LYON	M. H. Moseley	.....	.....
MUHLENBERG	R. E. Davis	Present	Present
TODD	R. D. Lynn	Present	Present
TRIGG	Elias M. Futrell	Present	.....

Fourth District

County		First Session	Second Session
BRECKINRIDGE	James G. Sills	Present	.....
BULLITT	P. J. Murphy	Present	.....
	James W. Roney (Alter.)	.....	Present
GRAYSON			
GREEN	J. W. Miller	Present	Present
HARDIN	Charles F. Long	Present	Present
HART			
LARUE	J. D. Handley	.....	.....
MARION	David Drye	.....	.....
MEADE	George E. Clark	.....	.....

Speaker of the KSMA House of Delegates Garnett J. Sweeney, M.D., Liberty, right, briefs reference committee chairmen on Monday, September 23 at a special luncheon for the reference committee chairmen following the opening session of the House of Delegates. In the top row, left to right are: George F. Brockman, M.D., Greenville, Vice-speaker of the House; Russell L. Hall, M.D., Prestonsburg, and Kenneth M. Eblen, M.D., Henderson. From left to right, seated are: Hollis Johnson, M.D., Louisville, M. Randolph Gilliam, M.D., Lexington, E. C. Seeley, M.D., London, and Paul Parks, M.D., Bowling Green. Ballard Cassady, M.D., Pikeville, was attending another meeting when the photo was made.

Immediately following being chosen president-elect of the Kentucky State Medical Association, Delmas M. Clardy, M.D., Hopkinsville, addresses the second meeting of the House of Delegates on September 25.

NELSON	Emmett W. Wood	.....	Present
SPENCER	M. H. Skaggs	.....	.....
TAYLOR	W. R. Mann	Present	Present
WASHINGTON	M. A. Coyle (Alter)	Present	Present
	H. B. Simms	.....	.....

Fifth District

JEFFERSON	John D. Allen, Jr.	Present	Present
	Frank A. Becbtel	Present	.....
	C. Melvin Bernhard	Present	Present
	Elbert G. Christian	Present	Present
	Morgan R. Colbert	Present	Present
	Michael R. Cronen	Present	Present
	James Davis	.....	Present
	Ralph M. Denham	Present	Present
	James B. Douglas	Present	Present
	William C. Durham	Present	Present
	Elbert L. Dennis (Alter.)	Present	.....
	Rudy J. Ellis	.....	.....
	A. L. Goodman	Present	Present
	George A. Sehlinger (Alter.)	Present	Present
	John Hemmer	.....	Present
	Hollis Johnson	Present	Present
	Richard Mardis	Present	Present
	George F. McAuliffe	Present	Present
	Herman Moore	Present	Present
	E. Frank Radmacher	Present	Present
	Johnny G. Reynolds	Present	Present
	Robert C. Long	.....	.....
	Paul J. Ross	Present	Present
	Henry Saam	Present	.....
	William P. VonderHaar (Alter.)	Present	Present
	Bernard Schoo	Present	Present
	Samuel M. Smith	Present	Present
	Jerry Smith	Present	Present
	Robert C. Tate	Present	Present
	George I. Uhde	Present	Present
	Edward Warrick, Jr.	.....	Present
	Sam Weakley	Present	Present
	Robert L. McClendon	Present	Present

Sixth District

ADAIR	J. C. Salato	Present	Present
ALLEN	Earl Oliver	.....	.....
BARREN	Eugene L. Marion	.....	.....
	John Dickinson (Alter.)	Present	.....
	Daryl Harvey (Alter.)	.....	Present
	W. H. Bryant	.....	.....
BUTLER	John C. Burris	.....	Present
CUMBERLAND	Joseph Schickel	.....	.....
EDMONSON			
LOGAN	W. R. Byrne	Present	.....
METCALFE	P. D. Hitchcock	.....	.....
MONROE	C. A. Crabtree	.....	.....
SIMPSON	L. F. Beasley	.....	Present
WARREN	Paul Parks	Present	Present
	L. M. Wilson	.....	Present
	James Willoughby	.....	.....

Seventh District

ANDERSON	Boyd Caudill	.....	.....
CARROLL	Edgar S. Weaver	Present	Present
FRANKLIN	Harry J. Cowherd (Alter.)	Present	Present
	John Stewart	.....	.....
GALLATIN	J. E. Esteves	.....	Present
GRANT	F. R. Scroggin	Present	Present
HENRY	Shelby Hicks	.....	.....
OLDHAM	H. Burl Mack (Alter.)	Present	Present
	E. G. Houchin	.....	.....
OWEN	O. A. Cull	.....	.....
SHELBY	M. D. Klein	.....	.....
TRIMBLE	Carl Cooper	Present	Present

Eighth District

BOONE	Philip Schworer	.....	.....
CAMPBELL-KENTON	Carl J. Brueggeman	Present	Present
	Thomas Huth	.....	.....
	James F. Siles (Alter.)	.....	Present
	Donald Janney	Present	Present
	R. Charles Smith	Present	Present
	Richard Allnutt	Present	Present
	Paul Klingenberg	Present	Present

Ninth District

BATH	Robin A. Byron	.....	.....
BOURBON	R. J. Wever	Present	.....
BRACKEN	J. M. Stevenson	Present	Present
FLEMING	R. W. Fidler	.....	.....
HARRISON	H. H. Moody	Present	.....
MASON	J. E. McKinney	.....	Present
NICHOLAS	W. R. Kingsolver	Present	.....
PENDLETON	Robert L. McKenney	.....	.....
ROBERTSON			
SCOTT	J. C. Cantrill	Present	Present

Tenth District

FAYETTE	W. L. Boswell	Present	Present
	N. L. Bosworth	Present	Present
	Harvey Chenault	Present	Present
	Carl H. Fortune	Present	Present
	M. R. Gilliam	Present	Present

CONGRATULATIONS, POP!—Following his installation as president of KSMA at the second meeting of the House, George P. Archer, M.D., is congratulated by his son, Raleigh, a junior at the U.K. College of Medicine, and his bride. Mrs. George Archer, right, looks on.

NEW OFFICERS—Following the second session of the House of Delegates on September 25, the new officers of KSMA pose in the Crystal Ballroom of the Phoenix Hotel. From left to right are: George P. Archer, M.D., president; Delmas M. Clard, M.D., president-elect; Carl C. Cooper, M.D., vice-president (Eastern); Carlisle Morse, M.D., vice-president (Central). The vice-president from the western section, John Dickinson, M.D., Glasgow, was unable to be present.

	L. E. Hurt	Present	Present
	Maurice Kaufmann	.....	Present
	J. T. McClellan	.....	Present
	J. H. Saunders	Present	.....
	Robert D. Shepard	.....	Present
	Andrew M. Moore (Alter.)	Present	.....
	E. C. Strode	Present	Present
JESSAMINE	J. S. Williams	Present	.....
WOODFORD	Ben F. Roach	Present	Present

Eleventh District

CLARK	J. Watts Stovall	.....	.....
ESTILL	S. G. Marcum	.....	.....
JACKSON			
LEE	E. J. Broaddus	.....	.....
MADISON	William Epling	Present	.....
	William Clouse	Present	.....
MENIFEE	D. L. Graves	.....	.....
MONTGOMERY	R. J. Salisbury	Present	Present
OWSLEY	Mildred B. Gabbard	.....	Present
POWELL	S. T. Scrivner	.....	.....
WOLFE	Paul F. Maddox	.....	Present

Twelfth District

BOYLE	Chris S. Jackson	.....	.....
CASEY	Lewis Wesley	Present	Present
CLINTON	Ernest A. Barnes	.....	.....
GARRARD	Paul Lett	.....	Present
LINCOLN	H. I. Frisbie	.....	Present
McCREARY	T. C. VanArsdall	.....	.....
MERCER	M. A. Winchester	.....	.....
	J. S. Baughman (Alter.)	Present	Present
PULASKI	A. L. Cooper	.....	.....
	Robert F. Long	.....	.....
	Thomas J. Penn (Alter.)	.....	Present
ROCKCASTLE			
RUSSELL	Marshall M. Lawrence	.....	.....
WAYNE	Robert B. Breeding	.....	.....

Thirteenth District

BOYD	Guy C. Cunningham	Present	Present
CARTER	J. Watts Stovall	.....	.....
ELLIOTT	John F. Greene	.....	.....
GREENUP	Billy J. Riddle	.....	.....
LAWRENCE	Forest F. Shely	.....	.....
LEWIS			
MORGAN	Morris L. Peyton	.....	.....
ROWAN	S. E. Reynolds	Present	Present

Fourteenth District

BREATHITT	Robert E. Cornett	.....	.....
FLOYD	Russell L. Hall	Present	Present
JOHNSON	James W. Archer	Present	Present
KNOTT	M. F. Kelley	.....	.....
LETCHER	J. B. Tolliver	.....	.....
MAGOFFIN	Lloyd M. Hall	.....	.....
MARTIN			
PERRY	Mary Fox	Present	Present
PIKE	Ballard Cassady	Present	Present

Fifteenth District

BELL	M. J. Evans	Present	Present
CLAY	W. E. Becknell	.....	Present
HARLAN	E. M. Howard	Present	Present
	David M. Greeley	Present	.....
KNOX	H. L. Bushey	Present	Present
LAUREL	E. C. Seeley	Present	Present
LESLIE			
WHITLEY	Harold Barton	.....	Present

**The information in the roll call was taken from the attendance record cards signed by the delegates prior to the meetings on September 23 and 25.*

Grogan Named to KAOE Office

Bobby R. Grogan, director of field services for the Kentucky State Medical Association, was named first vice-president of the Kentucky Association of Organization Executives at the October 10-11 meeting held at the Brown Hotel in Louisville. Mr. Grogan has served for three years on the board of directors of the KAOE, and is also a member of the executive comittee. K. P. Vinsel of the Louisville Chamber of Commerce is president of the organization, and E. W. Kesler of the Kentucky Farm Bureau is secretary-treasurer.

Chairman of Reference Committee #3, E. C. Seeley, M.D., London, calls his committee to order on Monday afternoon, September 23. From left to right are: Doctor Seeley, James G. Sills, M. D., Hardinsburg, Bernard J. Schoo, M.D., Louisville, Frederick R. Scroggins, M.D., Dry Ridge, and James W. Miller, M.D., Greensburg.

Kentuckians to Participate In SMA Annual Meeting

Seventeen Kentucky physicians will take part in various phases of the 57th Annual Meeting of the Southern Medical Association set for November 18-21 in New Orleans. Also attending the meeting will be Sam A. Overstreet, M.D., Louisville, councilor from Kentucky for the SMA.

Scientific program participants and their topics will be: Rudolph J. Muelling, M.D., Lexington—"Ecthyma Contagiosum (Orf)", "The Pathologist as a Medical Witness", and "Opportunities in the Field of Pathology"; Herman Wing, M.D., Louisville—"Application and Use of Rehabilitation Centers by Industrial Medical Departments and General Practitioners" and "Diagnostic Values of Electrodiagnosis"; Douglas M. Haynes, M.D., and Harold Kasasky, M.D., Louisville—"Mixed Mesodermal Tumors of the Uterus"; John D. Gordinier, M.D., Louisville—"Vaginitis Study Culture."

Others are: Ralph M. Denham, M.D., Louisville—"Atrial Fibrillation without Evidence of Heart Disease"; Francis H. Bledsoe, M.D., Lexington— "Hypokalemic Nephropathy"; Roswell H. Fine, M.D., Lexington—"Emotionally Disturbed School-Failing Boys Treated in an Outpatient Clinic School"; John W. Greene, Jr., M.D., Lexington—"Therapy of Eclamptogenic Toxemia."

Also on the program are: C. Dwight Townes, M.D., Louisville—"Surgery in the Angle of the Anterior Chamber", and "Surgery of the Anterior Segment of the Eye"; Duane A. Schram, M.D. Williamson—"A Psychiatrist In Appalachia"; Robert Lich, Jr., M.D., and Lonnie W. Howerton, Jr., M.D., Louisville—"Hypospadias: A Modification of the Dennis Browne Procedure"; Andrew M. Moore, M.D., Lexington—"Congenital Hemangiomata"; Edward H. Ray, M.D., Lexington—"Role of Endoscopy in Diagnosis of Bladder Neck Obstruction".

Scientific exhibits will be presented by Thomas R. Marshall, M.D., J. T. Ling, M.D., R. Gonzalez, M.D., Irving Perlstein, M.D., F. Norman Vickers, M.D., and Samuel H. Cheng, M.D., all of Louisville.

Section officers attending the conference will be: Ralph M. Denham, M.D., Louisville, chairman, Section on Medicine; W. Vinson Pierce, M.D., Covington, secretary, Section on Urology; Herman Wing, M.D., Louisville, secretary-elect, Section on Industrial Medicine and Surgery; and Andrew M. Moore, M.D., Lexington, assistant secretary, Section on Plastic and Reconstructive Surgery.

Posthumous Award Presented

A posthumous award to E. L. Henderson, M.D., former Louisville Surgeon, was recently presented to Mrs. Henderson by the World Medical Association. Doctor Henderson, who died in 1953, was one of the first presidents of the World Medical Association, and at the same time served as president of the American Medical Association. He was graduate of the University of Louisville School of Medicine.

Doctor English Honored

John M. English, M.D., Elizabethtown general practitioner, was the guest of honor at a dinner given September 5 by the Hardin County Medical Society in recognition of its oldest member and his service to the community. July 1, 1963, marked the beginning of Doctor English's 62nd year in active practice.

A 1902 graduate of the Hospital College of Medicine in Louisville, he returned to his native Hardin County after practicing for two years in Harrodsburg.

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A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

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carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

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CSO-9193

Francis Massie, M.D., Lexington, right, and Ben Eiseman, M.D., professor and chairman of the department of surgery at the University of Kentucky College of Medicine, pose with a portrait of Doctor Massie which was recently hung at the University Medical Center. It is the first of several portraits of distinguished physicians planned for the Center.

Fayette, Jefferson Societies Sponsor TV Programs

A series of 26 weekly local television programs designed to inform the public on "the way in which doctors work," is being sponsored this winter by the Fayette County Medical Society.

The format of the program is closely related to the series presented for the last two years by the Jefferson County Society, in that each program of both series' includes a 15-minute film dramatizing one phase of a physician's practice in his specialty, followed by a panel discussion.

The Fayette County Series, which began September 15, will appear on Sunday afternoons and will be telecast as a public service. The Jefferson County Society has sponsored regular television programs for the past four years, beginning with the "Ask Your Doctor" series. This type of program is still used occasionally for special purposes.

The films utilized by both county societies were prepared by the California Medical Association and are titled "Doctors At Work."

Doctor Loveman on Program

Adolph B. Loveman, associate professor of dermatology and Syphilology at the University of Louisville, will be one of 17 guest speakers addressing the 28th Annual Meeting of the International Medical Assembly of Southwest Texas in San Antonio on January 30-February 1, 1964. Those interested in receiving further information about the assembly may write to William M. Center, President, 202 West French Place, San Antonio, Tex., 78212.

Doctor Massie's Portrait Unveiled At Med. Center

Francis Massie, M.D., clinical professor of surgery at U.K. and 1959 recipient of KSMA's Distinguished Service Award, was the subject of a portrait unveiled in a ceremony September 14 at the University of Kentucky Medical Center.

The portrait is the first of several that will eventually be hung on the walls of the Medical Center auditorium.

Doctor Massie is a former president of the Kentucky Medical Foundation. He has also served as president of the Fayette County Medical Society and the Southern Surgical Society.

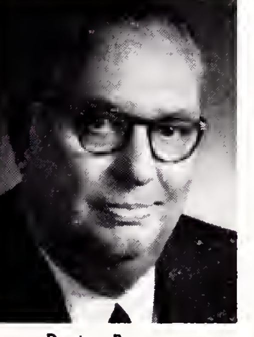
Doctor Massie joined the Lexington Clinic in 1924 after receiving his M.D. in 1919 from the University of Virginia. He was associated with the clinic until his retirement in 1962, and is now emeritus consultant in surgery at the clinic.

Ky. Physicians Present Paper

Harold D. Rosenbaum, M.D., Arthur Lieber, M.D., and Daniel J. Hanson, M.D., members of the staff of the department of Radiology at the University of Kentucky Medical Center, presented a paper on "Flat Films of the Abdomen on 500 Consecutive Patients over 40 Years of Age as a Survey Procedure," at the convention of the American Roentgen Ray Society October 8-11 at Montreal. The paper was one of more than 50 reports of progress in radiology made to the assembly.

Doctor Barnes Recognized By Clinical Scientists

Malcolm L. Barnes, M.D., Louisville pathologist, was honored as the Clinical Scientist of the Year by the Association of Clinical Scientists at the October 25-27 meeting of the Association held in Washington, D. C.



Doctor Barnes

The award is given annually to an investigator who has demonstrated outstanding zeal in the pursuit of clinical science. Doctor Barnes has conducted extensive research programs in general and clinical pathology, and has published many papers in this field.

An associate professor of Pathology at the University of Louisville School of Medicine, where he received his M.D. in 1935, Doctor Barnes has taken part in committee work within the Kentucky State Medical Association. He is a fellow of the College of American Pathologists, the Association of Clinical Scientists and a diplomate of the American Board of Pathology, and holds memberships in many other groups.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

In Kentucky

NOVEMBER

14 — Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.

14-16 — Clinical Application of Newer Immunological Concepts, Department of Pediatrics, University of Kentucky, Lexington, Ky.

21 — University Surgery Day, University of Kentucky, Lexington, Ky.

29 — Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

DECEMBER

5-7 — The Family Physician's Role in the Pre and Post Operative Patient, Department of Surgery, University of Kentucky, Lexington, Ky.

12 — Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.

19 — Annual Postgraduate Seminar, Norton Memorial Infirmary, Louisville, Ky.

19 — University Surgery Day, University of Kentucky, Lexington, Ky.

27 — Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

JANUARY

9 — Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.

15 — Cancer Teaching Lecture Series, University of Kentucky, Lexington, Ky.

16 — University Surgery Day, University of Kentucky, Lexington, Ky.

16 — Northern Kentucky Seminar, Kentucky Academy of General Practice, Cincinnati, Ohio.

24 — Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

Surrounding States

NOVEMBER

11-15 — American Public Health Association, Kansas City, Mo.

13 — Management of Diabetes Mellitus, Marion County General Hospital, Indianapolis, Ind.

13-14 — Advances in Internal Medicine, Cleveland Clinic Educational Foundation, Cleveland, Ohio.

18-21 — Southern Medical Association, Municipal Auditorium, New Orleans, La.

30-Dec. 1 — American College of Chest Physicians, (Interim Meeting), Portland, Ore.

DECEMBER

1-4 — American Medical Association (Clinical Meeting), Memorial Coliseum, Portland, Ore.

4-5 — Newer Developments in Ophthalmology, Cleveland Clinic Educational Foundation, Cleveland, Ohio.

10-12 — Southern Surgical Association, Hot Springs, Va.

11 — Pediatrics, Indiana University, Indianapolis, Ind.

12 — Pediatric Cardiology, Indiana University, Indianapolis, Ind.

JANUARY

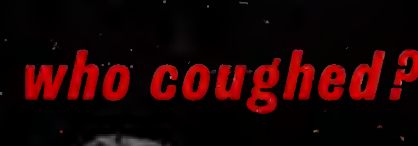
5-8 — The Cardiovascular System, 1st Annual Postgraduate Seminar in Anesthesiology, University of Miami and University of Florida, Miami, Fla.

8-9 — Treatment of Pulmonary Disease, Indiana University, Indianapolis, Ind.

13-17 — Vaginal Endocrine Cytology, Ohio State University, Columbus, Ohio.

22-23 — Dermatology, Indiana University, Indianapolis, Ind.

27-29 — American College of Surgeons, Baltimore, Md.



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Hydrocodone bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
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Sodium citrate		85 mg.

in a highly palatable, cherry-flavored vehicle (methylparaben 0.13% and propylparaben 0.02% as preservatives)

INDICATIONS: For both productive and nonproductive cough. For relief of symptoms in tracheitis, bronchitis, pneumonia, pharyngitis, bronchial asthma, pertussis, and allied conditions; cough associated with allergy; in general, whenever cough medication is indicated.

DOSAGE: Average adult dose—1 teaspoonful after meals and at bedtime with food. Children 6 to 12 years, ½ teaspoonful; 3 to 6 years, ¼ teaspoonful; 1 to 3 years, 10 drops; 6 months to 1 year, 5 drops; after meals and at bedtime. On oral Rx where state laws permit. U.S. Pat. 2,630,400.

CAUTION: Should be used with caution in patients with known idiosyncrasies to phenylephrine HCl and in patients with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients use should not exceed three days. Hycomine Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur. May be habit-forming.

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SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these rare instances withdrawal of medication is recommended. It is generally recognized that in pregnant patients all medications should be used cautiously, especially in the first trimester.

SUPPLIED: Bottles of 50 capsules.

Smith Kline & French Laboratories *Prescribing information Jan. 1963*

'63 KSMA Annual Meeting Praised by Guest Physicians

"It was indeed a pleasure to attend your Kentucky State Medical meeting and I am honored that you allowed me to participate on part of your program."

Paul W. Sanger, M.D., thoracic surgeon, Charlotte, N.C.

"I was very pleased to meet you, and let me assure you I had a very pleasant time on my visit to Lexington. I would like to thank you and your entire group for your hospitality."

Bernard Holland, M.D., professor and chairman, department of Psychiatry, Emory University School of Medicine

"I want to thank you and the Kentucky State Medical Association for inviting me to participate in the Annual Meeting in Lexington. I enjoyed attending the meeting and had a very pleasant visit in Lexington."

H. Hudnall Ware, Jr., M.D., professor and chairman, department of Obstetrics and Gynecology, Medical College of Virginia

"I have enjoyed my visit to Lexington very much and I want to congratulate you on the excellent organization of the meeting."

Christian R. Klimt, M.D., associate professor and director, Division of Epidemiology and Biostatistics, University of Maryland School of Medicine

"It was a real pleasure to attend the Kentucky State Medical Association meeting, and to have the privilege of participating in the scientific exhibits. I thought the other exhibits were very good and most informative and the scientific sessions were most interesting."

Charles H. Moore, M.D., Cincinnati, Ohio

"I enjoyed the meeting of the Kentucky State Medical Association and the hospitality of everyone that I met in Lexington. I thought that the meetings were excellent. I sincerely appreciate the invitation to have an opportunity to participate in this meeting."

Robert I. Wise, Ph.D., M.D., Magee Professor of Medicine, Jefferson Medical College of Philadelphia

"Needless to say, it was an enjoyable visit with your Association. Everyone was most hospitable to me."

Charles D. Carter, D.M.D., guest dental speaker, Bowling Green, Ky.

"I enjoyed the President's Luncheon at your Annual Convention. Congratulations upon such a successful meeting!"

Hasty W. Riddle, executive director, Kentucky Hospital Association

"Thank you very much for your kind invitation to sit at the speakers table during the President's Luncheon. I very much enjoyed the luuncheon and the speaker."

E. D. Pellegrino, M.D., professor and chairman, department of Medicine, University of Kentucky College of Medicine

During the President's Luncheon, U. of K. Student AMA president Ballard Wright, left, and James P. Moss, right, vice president of the U. of L. SAMA chapter, posed with KSMA president-elect George P. Archer, M.D., Prestonsburg, and Donn L. Smith, M.D., Dean of the U. of L. School of Medicine. William R. Willard, M.D., dean of the U. of K. College of Medicine, was unable to be present.

"Thank you very much for a nice visit to Lexington and the privilege of addressing the finest group of doctors I have seen anywhere in the country. It was a great audience."

Rev. Henry M. Johnson, D.D., Ph.D., Indianapolis, Ind., President's Luncheon Speaker

"I wish to thank you and the members of the Kentucky State Medical Association for a most enjoyable, as well as informative visit with your Association. It would be pleasant to return again to Kentucky and I certainly appreciate your advance invitation for 1964."

Charles L. Goodhand, M.D., president, West Virginia State Medical Association

"I want to express my appreciation for your kind invitation to attend the meeting of the Kentucky State Medical Association in Lexington. From a scientific standpoint the program was excellent. I picked up several ideas that I think would help us improve our program. I was impressed by the cooperation of the different specialty groups in presenting different aspects of the scientific program.

"The problems discussed in your House of Delegates were similar to some that we have at the present time at the Medical Society of Virginia. It is some comfort to know that other states also are looking for the answer. Your KEMPAC organization has done an excellent job in getting a third of your membership to sign up."

James M. Moss, M.D., first vice president, Medical Society of Virginia

"I much enjoyed meeting Kentucky physicians during the meeting of the medical association, including some old friends from New Haven. Thank you

for the hotel arrangements and the hospitality of the meeting."

Averill A. Liebow, M.D., professor of Pathology, Yale University School of Medicine

"Thank you very much for your kind words regarding my participation in the scientific assembly on Thursday, September 26, at the Kentucky State Medical Association meeting. I very much enjoyed the visit to Lexington and will recall it as a very pleasurable experience."

John R. Hodgson, M.D., associate professor of Radiology, Mayo Foundation, and consultant in Diagnostic Roentgenology, Mayo Clinic

Grace and I wish to thank you for the wonderful two days we spent with you in Lexington, at your Annual Meeting. Please convey our thanks and good wishes to Doctor and Mrs. Cox, Doctor and Mrs. Archer, as well as our official host and hostess—Doctor and Mrs. Pierce of Covington.

Horatio T. Pease, M.D., President, Ohio State Medical Association

Dr. Yocum Heads Orthopaedists

Thomas D. Yocum, M.D., Lexington, was elected president of the Kentucky Orthopaedic Society at the September 24 meeting held at the Phoenix Hotel in Lexington. He will succeed Charles F. Wood, M.D., Louisville, as president. New secretary-greasurer of the group is Wayne W. Kotcamp, M.D., Louisville, replacing William C. Mitchell, M.D., Louisville.

Doctor Dawson Honored

John E. Dawson, M.D., Newport, was named grand master of the Grand Lodge of Kentucky, Free and Accepted Masons, during the October 15-16 convention of the Lodge in Louisville. Doctor Dawson, a past deputy grand master, has been a Mason for 14 years.

Nursing Home Assn. Elects

James F. Buckner, Franklin, was named to head the Kentucky Association of Nursing Homes and Personal Care Homes at the group's 10th annual meeting held at the Sheraton Hotel in Louisville October 16.

Representatives from 118 homes registered for the meeting, which will be held in Paducah next year.

"R.N. of the Year" Named

Mrs. Stella T. Collins, R.N., a nurse for 50 years, was named "Registered Nurse of the Year" by the Kentucky State Association of Registered Nurses at the annual meeting of the group in Lexington October 16.

Mrs. Collins is a past president and member of the board of the organization. She graduated in 1913 from nursing school, retired after marriage, but returned to her profession during the 1918 flu epidemic, and is still active in her work.

Winner of the 1963 Scientific Exhibit Award was this exhibit on "Examination of the Stomach and Duodenal Bulb with the Fiberscope" prepared by F. Norman Vickers, M.D. (above), Thomas R. Marshall, M.D., and Samuel H. Cheng, M.D., of the departments of Medicine and Radiology at the University of Louisville. Receiving Honorable Mention for their exhibits were: J. C. Malek, M.D., Peter H. Jones, M.D., Leslie W. Blakey, M.D., and James T. McClellan, M.D., all of the Lexington Clinic; Charles H. Moore, M.D., and Khamis Saba, M.D., of Good Samaritan Hospital, Cincinnati; and Howard E. Dorton, M.D., Lexington.

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Pheniramine maleate	7.5 mg.
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Photo: N. & W. Engine No. 611, last of the famous "Class J" locomotives, on its final run between Roanoke, Va., and Williamson, W. Va., Oct. 26, 1959.

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After more than thirteen years and millions of prescriptions, no serious side effects have been reported from Robitussin. And patient acceptance has been outstanding.

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MEDICAL SCHOOL NEWS

Postgraduate Programs Set For U.K. Med. Center

"Professor's Day: A Colloquim in Internal Medicine for Family Physicians", will be presented by the department of Medicine on the first Thursday of each month at the University of Kentucky Medical Center. The first program of the series was held November 7.

The monthly meeting is designed for general practitioners and will offer an opportunity for the chairman of the department of Medicine to meet with small groups to discuss clinical areas of internal medicine of interest to them.

Each all-day program will include rounds with Edmund D. Pellegrino, M.D., professor and chairman of the department of Medicine with discussion of cases of interest; discussion of problems brought by the general practitioner. (Attending physicians may bring x-rays, and laboratory results, and may discuss diagnostic and therapeutic cases of their own.) Following luncheon, a seminar on a subject of topical interest will be conducted. The course has been approved for Category I credit by the American Academy of General Practice. No fee will be charged.

The College of Medicine will offer a postgraduate program entitled "Clinical Applications of Newer Immunological Concepts", to be presented by the department of Pediatrics November 14-16. The program will be open to pediatricians, general practitioners, and others whose major medical interests include problems of infancy and childhood.

For further information on either course, contact Nicholas J. Pisacano, M.D., Director, Continuation Medical Education, College of Medicine, University of Kentucky, Lexington, Ky.

TV To Aid Teaching

Closed-circuit television now being installed at the University of Kentucky Medical Center will provide additional instructional aids for the use of medical faculty and students, and may be tied in with similar installations in the Chemistry-Physics Building, the College of Dentistry, and the one planned for the Agriculture Sciences Building.

The $32,000 installation in the Medical Center consists of control panel devices, two cameras and three monitors. Eventually 44 monitors throughout the Center will be put into use. A fixed camera will be used in the hospital's large operating room.

It is hoped that the television network may be used to pick up case presentations originating in Lexington hospitals, as well as in the production of programs to be taped for use over the statewide Educational Television Network.

The University of Kentucky College of Medicine announces three recent faculty appointments. They are: Carol Currier, M.D., assistant professor, department of psychiatry; Donald Edward Edger, M.D., instructor part-time, department of obstetrics and gynecology; and Charles L. Preston, M.D., instructor, department of clinical obstetrics and gynecology.

The Board of Trustees recently accepted a grant from the National Foundation to finance the staffing of a Birth Defects Special Treatment Center at the University Medical Center. James W. Rackley, M.D., part-time instructor in the department of Pediatrics, will serve as program director of the center.

The Birth Defect Special Treatment Center will be able to provide evaluation, diagnosis, outpatient therapy, and consultation, for children with any physical defect they are born with, or children with any inborn error of metabolism.

The Center, which has already been activated, will not have a specific space allotment, but will use the various University Hospital clinics, depending upon the needs of the patient.

The National Foundation grant, in the amount of $20,500, will be given by the Fayette County Chapter and other National Foundation Chapters in Kentucky, and will provide for the personnel and operation of two laboratories.

Mrs. Edwin Munich of Lexington has announced that she will establish an Edwin Munich Memorial Fund in honor of her late husband, for the purpose of an annual medical lecture at the University Medical Center.

Mrs. Munich's son, Richard Munich, is a third year student in the College of Medicine.

U. of L. Announces Changes In Faculty Appointments

S. Spafford Ackerly, M.D., was recently appointed by the U. of L. Board of Trustees as psychiatrist-in-residence for 1963-64. Doctor Ackerly is former chairman of the department of psychiatry.

The following changes in the status of U. of L. faculty members were approved by the Board: *Appointments*—Walter R. Morris, M.D., clinical instructor in ophthalmology; Temple B. Stites, M.D., clinical instructor in medicine; Alfred E. Mattox, M.D., clinical instructor of anesthesiology; Col. Samuel H. Sandifer, M.D., clinical associate in pediatrics; Armin Frederich Haerer, M.D., clinical instructor in medicine (neurology); Leonard A. Goddy, M.D., clinical instructor in orthopedic surgery; David Shipp, M.D., clinical instructor in surgery; Norton G. Waterman, M.D., assistant professor of surgery; and Robert J. McGrath M.D., clinical instructor in obstetrics and gynecology.

Promotions—Orville S. Clark, M.D., to assistant clinical professor of anesthesiology; Blaine Lewis, M.D., to assistant clinical professor of surgery; Taha S. Anvari, M.D., to assistant professor of neurology; Gaspar Carrasquer, M.D., to associate professor of experimental medicine; and Stuart Urbach, M.D., Samuel M. Smith, M.D., Robert L. McClendon, M.D., John S. Llewellyn, M.D., Stuart Graves, Jr., M.D., Abraham M. Gordon, M.D., and Robert J. Alberhasky, M.D., all to assistant clinical professors of medicine.

Resignations—William G. Ellis, M.D., Jack L. Mulligan, M.D., and Wilson C. Williams, M.D., instructors in medicine; and Edward L. Foote, M.D., assistant professor of pathology.

H. Hart Hagan, M.D., has been appointed professor emeritus of surgery, and Max Erwin, M.D., has announced his resignation as instructor in anesthesiology. Nathan Handelman, M.D., assistant professor of pediatrics, has been granted a leave of absence to accept a year's full-time fellowship in pediatrics (allergy) at the University of Kentucky. Cathryn Handelman, M.D., assistant professor of pediatrics, has been granted a leave of absence to take over her husband's practice while he is at U.K.

Other Appointments

Austin Kellett Letson, lecturer in occupational health in the department of community health; Lipman Joseph Klein, M.D., instructor in medicine (neurology); John Roberts Hoard, instructor in ophthalmic research, department of ophthalmology; Arthur Siegel, M.D., instructor in pathology; Robert A. Clary, M.D., instructor in psychiatry; Inez Busch Ice, M.D., part-time instructor in psychiatry; William W. Joule, M.D., instructor in radiology; Robert L. Keisler, M.D., instructor in orthopaedic surgery; and Joseph E. Kutz, M.D., instructor in surgery.

Frederick P. Shepherd, M.D., and E. Leslie Van Nostrand, Jr., M.D., assistant professors of occupational health, department of community health; Bill M. Adams, M.D., Bernard Barron, M.D., Alvin Churney, M.D., Louis Giesel M.D. and Margaret Vermillion MD., assistant professors of pediatrics; Wilber A. Mitchell, M.D., nad Theodore A. Schramm, M.D., assistant professors of psychiatry; Thomas M. Marshall, M.D., assistant professor of neuro-surgery; and Roy S. Giffiths, Ph.D., assistant professor of ophthalmic research, and associate in psychiatry.

Grants for medical and social research in tuberculosis and other respiratory diseases are available from the American Thoracic Society, according to William R. Barclay, M.D., society president. Further information and application forms may be obtained from the society's offices at 1790 Broadway, New York 19, New York.

The American College of Allergists Graduate Instructional Course and Twentieth Annual Congress is scheduled for March 1-6, 1964, at the Americana, Bal Harbour, Miami Beach, Florida. For additional information write: John D. Gillaspie, M.D., treasurer, 2141 14th St., Boulder, Col.

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News Notes

Harold B. Graves, M.D., clinical instructor of obstetrics and gynecology at the U. of L. School of Medicine, retired September 24 after 29 years of military service. Doctor Graves, who holds the rank of Colonel, has been commander of the 123rd Tactical Hospital of the Kentucky Air National Guard for the past five years.

W. B. Atkinson, M.D., former Lebanon physician and surgeon, recently retired from private practice there and has taken the post of full-time Taylor County Health officer. He succeeds **Genrose DeSimone, M.D.,** who is now with the U.S. Public Health Service.

James R. Schrand, M.D., who graduated from the University of Louisville School of Medicine in 1960, recently started in general practice in Florence in association with **L. C. Hess, M.D.** Doctor Schrand interned at St. Elizabeth Hospital, Covington. He served as a captain in the USAF in 1961-63.

The neurosurgical service at the Memorial Medical Center, Williamson, West Virginia, has been re-established with **H. Russell Meyers, M.D.,** as chief of neurosurgery. Before joining the staff at the Memorial Medical Center he had been chairman of the division of neurosurgery at the State University of Iowa Hospitals since 1946 and, since 1949, professor of surgery at the same university.

Lee Chadwick Shine, M.D., has recently become associated with **Irving F. Kanner, M.D.,** in the practice of internal medicine in Lexington. A native of Tennessee, Doctor Shine graduated from Vanderbilt Medical School in 1959. He took his internship training at Barnes Hospital, St. Louis. Following a three year residency at Barnes, he was chief resident in medicine at the University of Kentucky for a year.

James O. Nall, M.D., Smithland, has recently been appointed as Public Health officer of Crittenden, Livingston, Lyon, and Caldwell Counties, succeeding **Dillard D. Turner, M.D.,** who has returned to private practice in London, Ky. The former Marion physician was Health Officer in the same district twice before —early in 1940 and again in 1953-55.

James E. Gamble, M.D., has become associated with the Trover Clinic at Providence for the general practice of medicine. Doctor Gamble graduated in 1960 from the University of Louisville School of Medicine and interned at Jackson Memorial Hospital, Miami, Fla. Prior to entering practice in Providence Doctor Gamble served as a Captain in the U. S. Army.

Asa Barnes, M.D., area administrator for the United Mine Workers Welfare and Retirement Fund in Louisville since 1948, has been transferred to West Virginia, according to an announcement from the Washington office of the executive medical administrator for the welfare fund.

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY

CASE #130—A 31-year-old married gravida 5 para 4 was first seen in November, 1960. Her expected date of delivery was May 16, 1961. The past history was negative except for an appendectomy in 1947. The past obstetrical history was uncomplicated except for the fact that the patient's last pregnancy, in 1957, had resulted in delivery of a child with cerebral palsy.

On April 29, the patient was hospitalized because of spontaneous rupture of the membranes. Forty-eight hours later, a pitocin induction was attempted, but proved unsuccessful. A consultant recommended delivery by Cesarean section because the patient and her husband had both requested that a post-partum sterilization be performed.

On April 29, a classical Cesarean section was performed under spinal anesthesia, with delivery of a living infant girl. The placenta was removed manually and the uterus sutured in three layers. A bilateral tubal ligation was then done, and the abdomen was closed. Toward the end of the operation, the patient suddenly went into shock and began bleeding profusely. Because the blood did not appear to clot, the diagnosis of afibrinogenemia was made and multiple transfusions together with three units of fibrinogen were administered. A suspected ventricular fibrillation responded to pronestyl hydrochloride. The blood pressure was maintained at 160/80 by means of a levophed drip. When this was discontinued after an unspecified interval, and blood was being administered through an ankle vein, the systolic blood pressure became stabilized at 118 mm Hg with a pulse rate of 140. On April 30, the patient was examined by a surgical consultant because of a tentative diagnosis of intra-abdominal hemorrhage. At this time she was unconscious. The temperature was 107°, and the heart rate was regular but fast, corresponding to the pulse rate. Coarse and fine rales were heard throughout both lung fields. The abdomen was distended but soft, giving rise to the clinical impression of paralytic ileus. The consultant suggested that periodic hemoglobin and hemotocrit levels be obtained and that as long as the hemotocrit continued to rise and the blood pressure could be stabilized by means of whole blood, exploratory operation should be delayed. Vigorous treatment of pulmonary edema and antipyretic measure were also recommended. This regimen was followed until 10:15 A.M. on May 1, when the patient died as a tracheotomy was being performed.

The abdomen was opened immediately after death. The peritoneal cavity contained 1,000 cc of blood. The suture line in the uterus seemed to be healing. The bowel showed widespread petechiae, and the congested liver edge was 2 fingerbreadths below the right costal margin. All other organs and tissues appeared normal. The recorded cause of death was pulmonary edema, profound shock due to blood loss, and acute afibrinogenemia.

COMMENTS

The committee considered this case to be one of direct obstetrical death with preventable factors. The stated indication for the Cesarean section, desire for sterilization, was questioned, but several committee members thought that the abdominal delivery was justified because of failure of induction of obligation because of ruptured membranes for 48 hours. The sudden shock noted at the completion of the operation was considered highly suggestive evidence in intra-abdominal bleeding, and this presumption later corroborated by the finding of an estimated liter of free blood in the abdomen. The now almost automatic immediate postmortem presumptive diagnosis of hypofibrinogenemia whenever sudden shock is observed was decried by the committee: in the present case, this probably erroneous diagnosis may have deterred the operating surgeon from reopening the abdomen to secure immediate definitive (and life-saving) hemostasis.

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Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; in some patients 100 mg. three or four times daily suffices. Children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Reference: 1. A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963.

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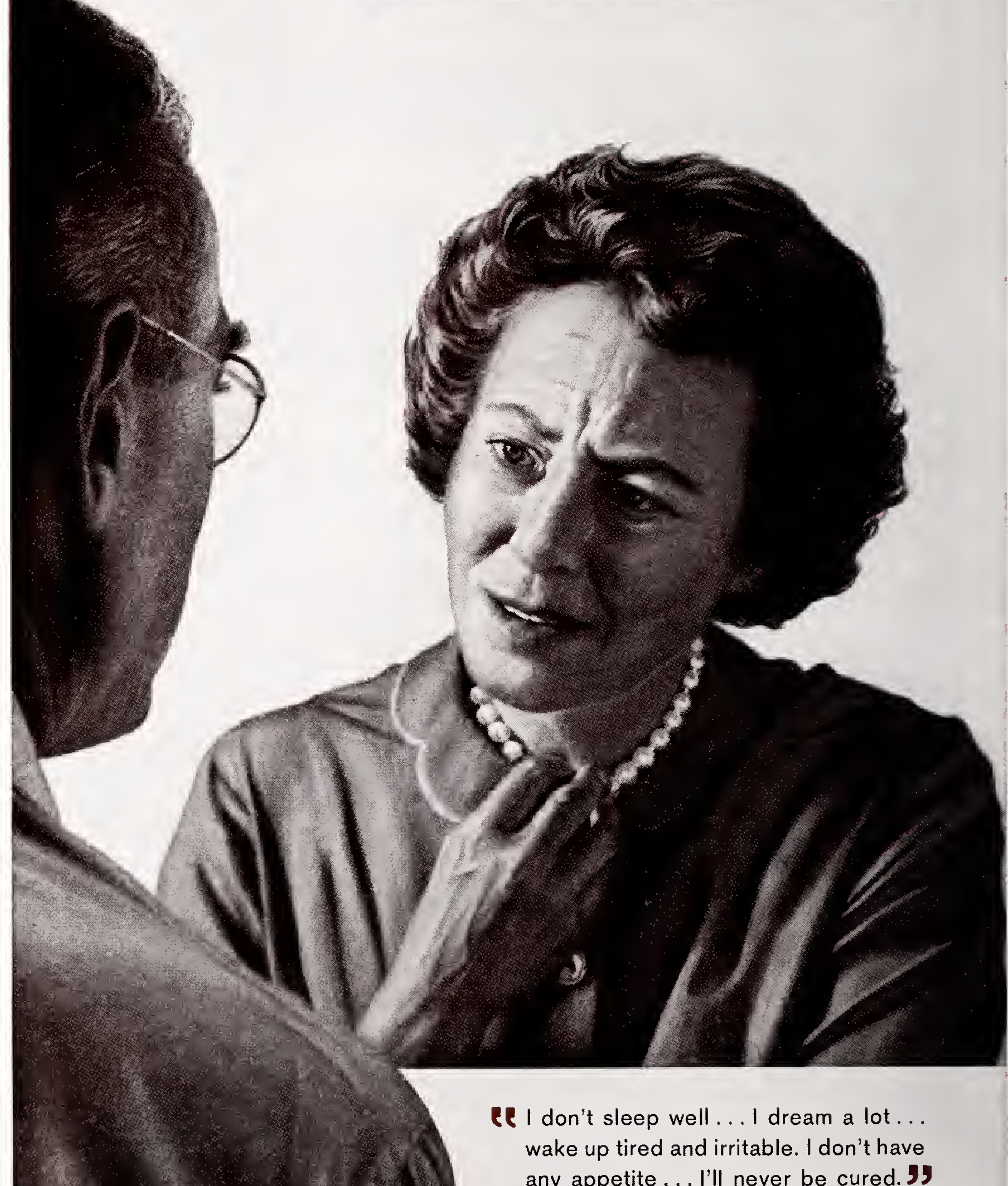

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In Memoriam

LANIER LUKINS, M.D.
Louisville
1912-1963

Lanier Lukins, a Louisville surgeon, was killed in a head-on collision of automobiles on Interstate 64 on September 19. Doctor Lukins graduated from the University of Louisville School of Medicine in 1937. He took his internship at Cook County Hospital, Chicago, and did postgraduate work at the Post-graduate Hospital, New York City. Doctor Lukins had completed two years in general surgery at Veterans Hospital, Louisville. He was a fellow of the American College of Surgeons and a member of the Southeastern Surgical Congress and the Kentucky Surgical Society.

H. STUART HODGES, M.D.
(formerly) Alva
1888-1963

Henry Stuart Hodges, M.D., 75, retired general practitioner, died October 6 in Knoxville, Tenn., where he had lived for some time. Doctor Hodges, a 1917 graduate of the Stritch School of Medicine at Loyola University, Chicago, practiced medicine at Alva, Ky., for more than 20 years before moving to Oak Ridge, Tenn. He retired 10 years ago.

MARSHALL M. LAWRENCE, M.D.
Jamestown
1890 - 1963

Marshall M. Lawrence, M.D., 73, Jamestown general practitioner, died October 9 in Louisville after an illness of several months. A native of Clinton County, Doctor Lawrence graduated in 1913 from the Medical Department of the University of Louisville. He had practiced in Russell and surrounding counties for 50 years.

EMORY L. DRAVO, M.D.
(formerly) Louisville
1889 - 1963

Emory L. Dravo, M.D., 74, former assistant clinical professor of medicine at the University of Louisville School of medicine, died at his home in El Cajon, Calif. on September 22. Doctor Dravo, a native Kentuckian, was graduated from the U. of L. School of Medicine in 1911. From 1914 until 1938, when he left Louisville, he served on the faculty of the department of Medicine. He was also a former chief of psychiatry at the Oakland, Calif. Medical Hospital.

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Continued from Page 998

amination. Some of the more pertinent factors in the etiology, pathogenesis, and treatment of syndrome are discussed.

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Pertinent Paragraphs

An international postgraduate course in "Introduction to Fundamentals of Reconstructive Surgery of the Nasal Septum and External Pyramid" will be presented at the University of Cincinnati College of Medicine and Christ Hospital, Cincinnati, May 5-15, 1964. Further information may be obtained from Dr. Raymond L. Hilsinger, 2403 Auburn Avenue, Cincinnati 19, or American Rhinologic Society, 530 Hawthorne Place, Chicago 57.

A special postgraduate course in Laryngology and Bronchoesophagology will be given March 16 through 28 by the University of Illinois College of Medicine, department of otolaryngology. Registration will be limited to 15 physicians. Interested registrants will please write directly to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Ill.

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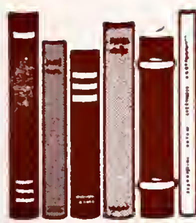

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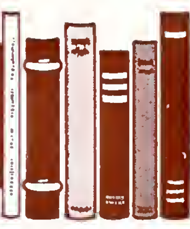

ELECTROCARDIOGRAPHY FUNDAMENTALS AND CLINICAL APPLICATION (Third Edition); By Louis Wolff, M.D.; Published By W. B. Saunders Company, Philadelphia & London, 1963; 351 pages; price, $8.50.

The third edition of this book is essentially a review of the second edition with an attempt to utilize vectorcardiography in explaining the electrocardiograms.

There have been a few additions to this book which were not in the previous edition.

This book is presented in a conventional manner but has been "departmentalized" to the point of necessitating cross reference. This creates a rather awkward formulation of the material and makes reading slow and difficult. While all the essential elements of electrocardiography are presented, this book would be difficult for the beginning electrocardiographer to follow. For those more experienced in the field, the integration of this material might offer a challenge.

Henry W. Post, M.D.

CLINICAL GASTROENTEROLOGY (Second Edition): by Eddy D. Palmer, M. D. Published by Hoeber Medical Division, Harper & Row, New York, 1963; 706 pages; price $22.50.

This book is undoubtedly the most outstanding single-author treatise on gastroenterology by an American author. Dr. Palmer is one of this country's leading practicing gastroenterologists and endoscopists. His interests have always been in bedside medicine, and it is from this point of view that this book is written.

The writing is concise and crystal clear. Dr. Palmer's subtle sense of humor is evident throughout the book, making for extreme readability. Photographs, x-rays, and diagrams are profusely used to good advantage. A series of drawings, repeated from the first edition, entitled "Pitfalls of Gastric Roentgenography" is recommended for anyone who orders upper gastro-intestinal x-rays.

Subject material is included in proper perspective. For example, Whipple's disease is given just over one page while the lowly appendix and appendicitis is given over nine pages.

Dr. Palmer summarizes his 12 years work, with over 800 cases, on the Vigorous Diagnostic Approach to upper gastrointestinal bleeding, in a few short pages. This involves active measures for diagnosis as soon as the patient is seen at the hospital including ice-water gastric lavage, esophagoscopy, gastroscopy, and upper gastrointestinal x-rays. His accuracy for determining the bleeding lesion is 90% compared to 70 to 75% accuracy in the traditional approach of waiting until after bleeding subsides before definitive diagnostic methods are used.

The opinions expressed in some areas are controversial. For example, uncomplicated duodenal ulcer is treated mainly by goal-directed interview.

This is not a book in which to seek an exhaustive review of an obscure point. I wish that the bibliography and indexing were more extensive. However, I frequently use the book as "the first place to look". If you are fortunate enough to own a 1957 edition, the second edition is not significantly different to warrant the expense. It is recommended, however, for students, house-officers, and practicing physicians who see patients with gastroenterologic complaints.

F. Norman Vickers, M.D.

MEDICINE AND THE STATE: by Matthew J. Lynch, M.D., and Stanley S. Raphael, M.B., B.S.; published by Charles C. Thomas, Publishing Co., Springfield, Ill., 1963; 423 pages; price, $9.75

The authors have made a comprehensive review of medical care in various countries with government medicine. They have reviewed medical care in the USSR, England, New Zealand, Sweden, Australia, Germany, and Austria. The historical development of medical practice in these countries is carefully developed and well related to the present systems of medical care extant. Following survey of the medical systems in these countries an attempt is made to appraise the results of the various systems in economic, health, statistical, and professional terms.

This is a very well writen book that makes for easy reading. The book is complete, informative, and an important addition to this controversial subject. This subject does not lend itself easily to an objective study both because of the emotional involvement in the matter by almost all shades of society and because of the great difficulty in objectively evaluating the results of any particular system. For example, it is quite apparent from the beginning that the authors do not like government involvement in medical care nor do they like labor or socialist governments.

The difficulties in appraising the results of any system can be illustrated by the fact that while the incidence of disease in Austria and Germany, according to the authors, is high still, in England the incidence is quite low. While there may be a decline in the number of applicants to English medical schools, this is also true in America. If for the sake of argument, one accepts the authors' statement that medical research in England is on the decline, then one must explain why it is not on the decline, according to the authors, in Sweden, a country in which the government is equally involved in medical care. Finally, it is a fact that medical research in America has gained its great impetus since the government has subsidized this research.

Leonard Leight, M.D.

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(Q) *Is there a manual on the Senior Citizens Program?*

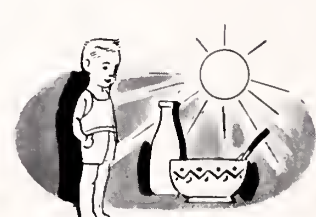
(A) One has been mailed to every doctor. Please write Blue Shield if you have not received your copy.

(Q) *Who determines whether a person covered under the Senior Citizen contract is a Service Benefit member?*

(A) The subscriber's identification card indicates by a "yes" or "no" whether the member is certified to eligibility for service benefits. If marked "yes," the subscriber stated his annual income was less than $2,500 single, $4,000 family.

(Q) *Were there any waiting periods under the Senior Citizens Program?*

(A) Yes. All contracts were effective January 1, 1963, and there was a six-month waiting period for pre-existing conditions.



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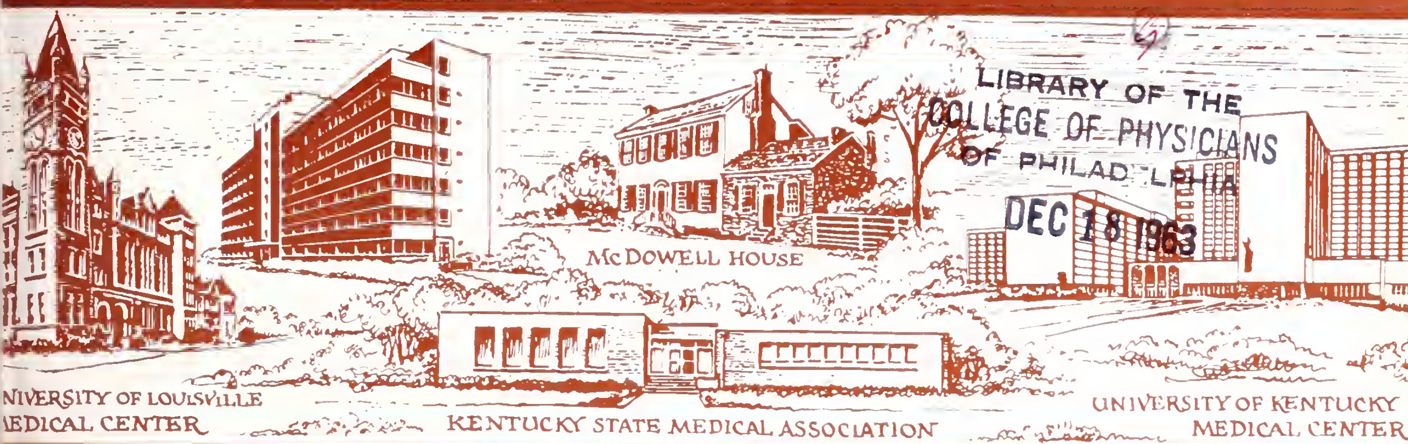

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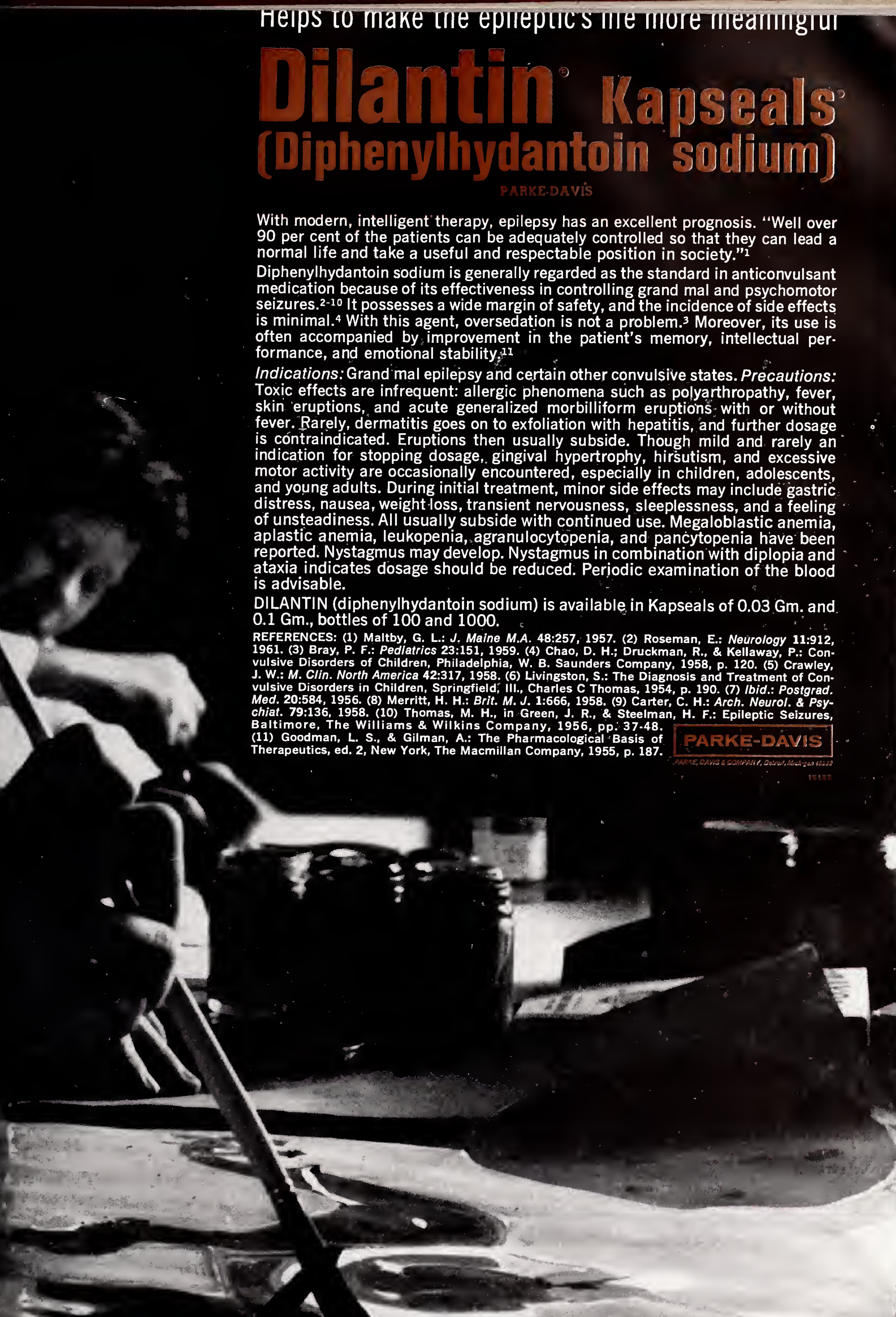
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give thanks for the many
things with which we are
blessed. This is the time when
our first consideration is to enjoy
the happiness of our families and
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Year.

George O. Archer M.D.

READY JANUARY FROM SAUNDERS

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Editor and Major Contributor, Charles Wesley Shilling, M.D., D.Sc., Consultant to the United States Atomic Energy Commission; Deputy Director, Division of Biology and Medicine, USAEC, 1955-60. With the Assistance of Miriam Teed Shilling, M.A. Prepared under the auspices of the Division of Technical Information, USAEC. 474 pages, 7¼" x 10¼", with 268 illustrations, 98 tables. About $10.50. *New—Ready January!*

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IN THE BOOKS

THE ENVIRONMENT OF MEDICAL PRACTICE: Edited by R. B. Robins, M.D.; Published by Yearbook Medical Publishers, 1963. 357 pages.

The purpose of this book is to acquaint both the practitioner of medicine as well as the senior medical student with the socio-economic and ethical phases of medical practice. As such, this book is a pioneer in its field and fills a very real void in the field of medical education.

The truth is that a paradox has long existed in medical education. On the one hand the recent graduate is usually well prepared in the basic medical disciplines, laboratory medicine and diagnosis, while on the other hand almost all will agree that he is rather poorly prepared for the actual care of patients. He knows little or nothing of the art of medicine. Probably no one is as unprepared or naive concerning the economics of his business or profession as is the young physician. He will conduct himself with a most exacting code of ethics, yet his knowledge of medical ethics is almost nil. The same can be said of his knowledge of organized medicine and its purposes, of hospital-physician relations, of voluntary health insurance and many other important fields that are a vital part of his daily medical environment.

This book covers these and related subjects and does it well. Doctor Robins, the editor, is to be commended, not only because he realized the need for such a volume as this, but also in his selection of contributors.

Your reviewer hopes that each medical school will, in the near future, institute a course in medical civics. This book would be an excellent text for just such a course.

Robert C. Long, M.D.

HANDBOOK OF PEDIATRICS: by Henry K. Silver, M.D., C. Henry Kempe, M.D., and Henry B. Bruyn, M.D.; published by Lange Medical Publications, Los Altos, Calif., 1963; 583 pages; price, $4.00.

This volume is a handbook in size, format and content. It presents to the practicing physician and medical student a concise and readily available digest of the material necessary for the diagnosis and management of pediatric disorders.

The fifth Edition differs in only a few respects from the fourth (1961). Some of the changes are: revision of immunization schedule to include the Sabin polio vaccine and comments on the measles vaccine; addition of the Apgar rating for the newborn; mention of albumin loading prior to exchange transfusion; new sections on the battered child syndrome, adreno-cortical and corticotropin steroid therapy and plasma cell hepatitis. The section of glycogen storage disease is discussed and classified according to O'Brien and Ibbott's adaptation.

By necessity oversimplified and dogmatic in many instances, it is not intended to replace the standard textbook in Pediatrics. The success of previous editions should continue with the present handbook. It should be in the pocket of every house-officer and in the library of each physician practicing pediatrics.

Walter T. Hughes, M.D.

COUNSELING IN MEDICAL GENETICS: by Sheldon C. Reed, Ph.D.; published by W. B. Saunders Co., Philadelphia, 1963; 278 pages; price, $5.50.

The first edition of this book had a wide acceptance and popularity amongst physicians. There were three reasons: it was needed; it was written by an expert; it was highly readable. Now Dr. Reed has responded to the need for virtually re-writing the book because of the phenomenal continuing advances in knowledge in the field of Medical Genetics. Not only in his Dight Institute for Human Genetics have there now been counseled over 2500 families but much detailed work on genetics applicable to medicine has appeared of late.

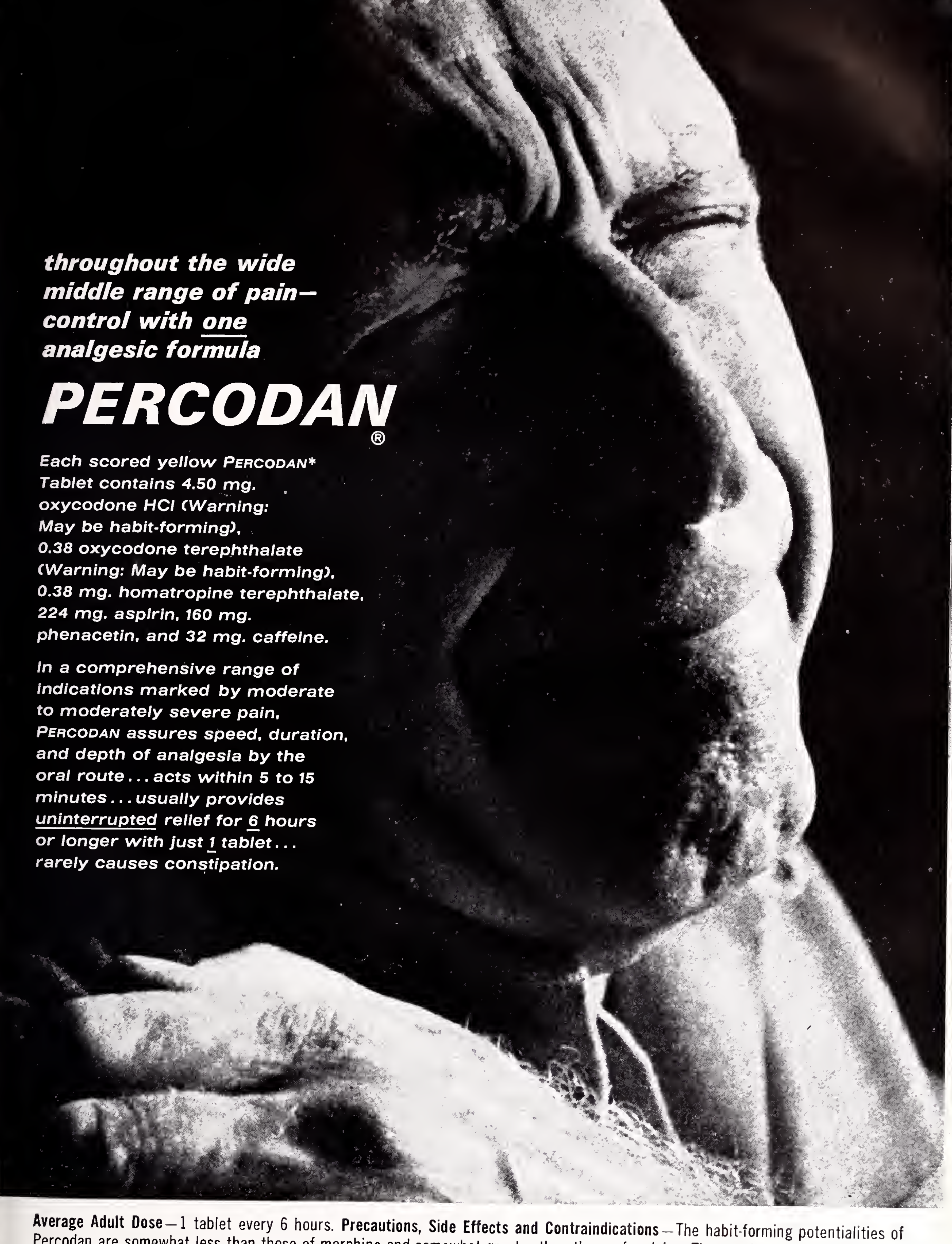
The ability to "counsel genetically" is something which it is difficult to imagine lacking in a fully equipped physician—especially a pediatrician and obstetrician. But this awareness only came for this reviewer after seeing some experts at work, and reading this book. It is clear, by absorbing the contents, we can do a reasonable job and greatly enhance our usefulness.

Particular chapters which stand out are "The Common Carrier," "Mental Retardation," "Cancers," "The Psychoses,'" and "Downs Syndrome." At the close of each are illustrative examples showing how, in practice, the trained physician deals with specific counseling problems—possibly the best attribute of the book.

The author writes in a curious chatty style and were it not for his great and justified reputation, this might be irritating. There are very many tiny paragraphs that remind one of classical stories like those from "A House of Pomegranates."

The references are good but in some areas controversial—for example in Convulsive Seizures. But all in all: "It is my hope that this book will give the physician better background with which to answer the questions in human genetics which pop up at the most unexpected times . . . it was so much fun writing this book, even though for the second time that some of the pleasure ought to rub off onto the reader." It did on this reviewer and he gained much from it.

Frank Falkner, M.D.



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PUBLIC HEALTH PAGE

Why Report Rheumatic Fever?

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

WE are far from conquering rheumatic fever. From two to five out of every thousand children with a streptococcal sore throat will subsequently develop this malady because of lack of treatment or inadequate treatment. About half of these cases will ultimately develop rheumatic heart disease. Each year in Kentucky over 200 people die as a result of this potentially preventable disease. Yet, mortality alone is only a small measure of its impact when compared to the chronic physical and emotional disability it produces in an age group otherwise considered to be in the prime of life.

The only primary preventive measure currently available is the antibiotic treatment of group A beta hemolytic streptococcal infections, precursor to rheumatic fever. The key to this at present is large scale throat culturing to identify streptococcal infections. The fluorescent antibody technique, currently in use at the Kentucky State Health Department, has proved to be a valuable diagnostic tool in identifying this organism. Within four hours after throat culture is received in the laboratory, a report could be available to the physician who might otherwise have to wait 24-48 hours for a report by conventional bacteriologic methods. As this technique gains wider acceptance, private laboratories not already doing so should also be able to offer this diagnostic service.

Despite the fact that rheumatic fever is, by law, a reportable disease in Kentucky, the actual incidence remains unknown because reporting is inadequately done. Since the only recognized way to prevent recurrent attacks of rheumatic fever is to place persons who have had an attack on continuous prophylaxis, a case registry must be kept carefully and currently.

According to the U.S. Public Health Service, "A functioning case registry is essentially a perpetual inventory of the community's rheumatic fever and rheumatic heart disease patients. Its purposes are to call attention routinely to patients for whom there is no recent report, and who, therefore, are likely to have discontinued medical supervision or prophylaxis; to provide a summary history of each case in order to facilitate review by the medical director and the nursing supervisor or consultant, and to aid them in making decisions regarding follow-up and services; and to provide basic data needed for planning, managing, and evaluating the program."

On-Going Program

The rheumatic fever prophylaxis program has been in operation in Kentucky since 1955. This program provides penicillin through local health departments to medically indigent patients. At the present time there are approximately 5,000 persons on the registry, 2,500 of whom are currently receiving penicillin.

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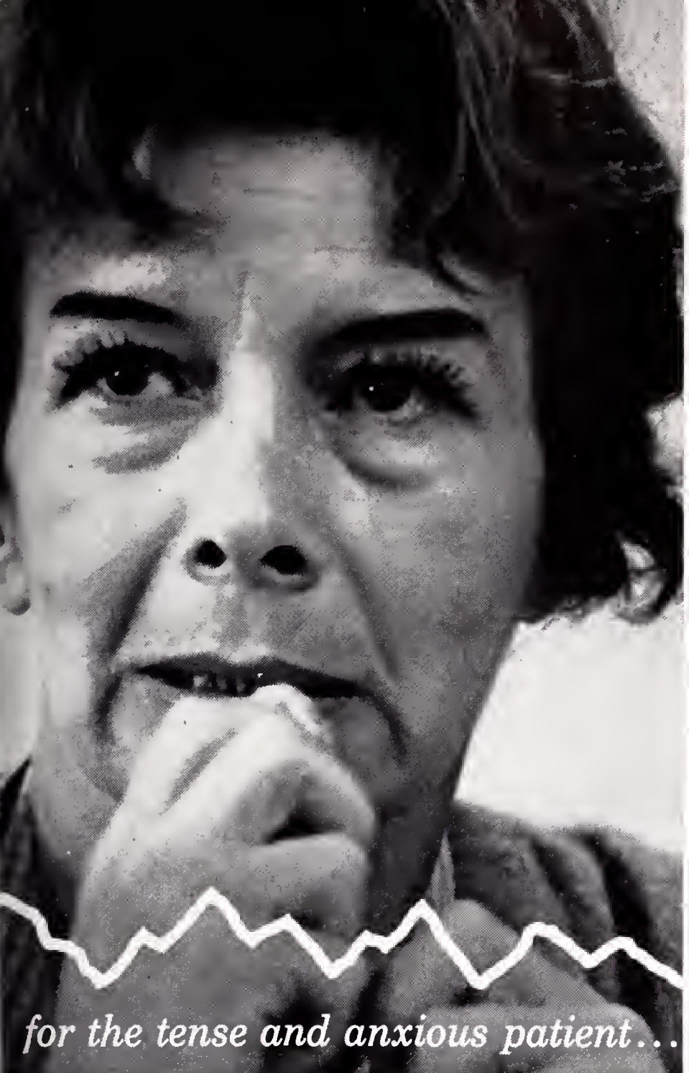
This article was prepared by Stephen G. Edelstein, M.D., Heart Disease Control Officer, Kentucky State Department of Health, 275 East Main Street, Frankfort, Kentucky



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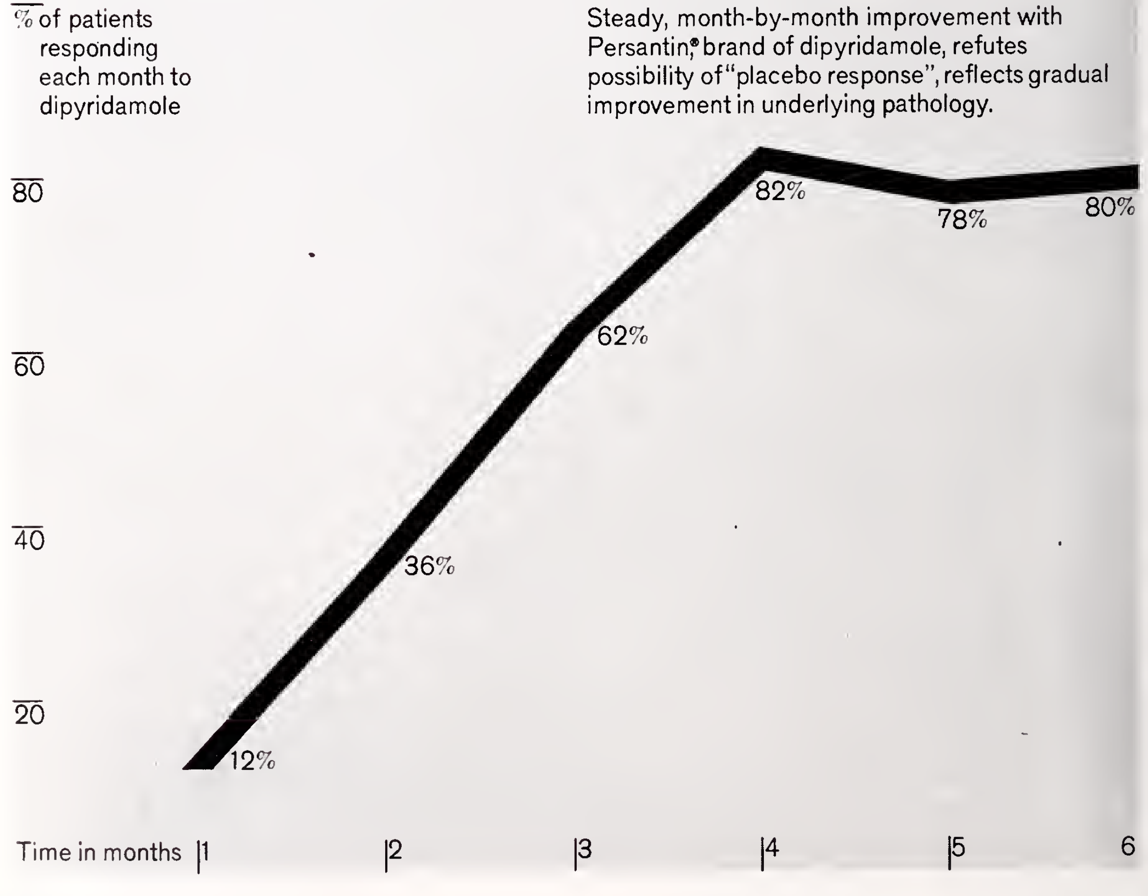

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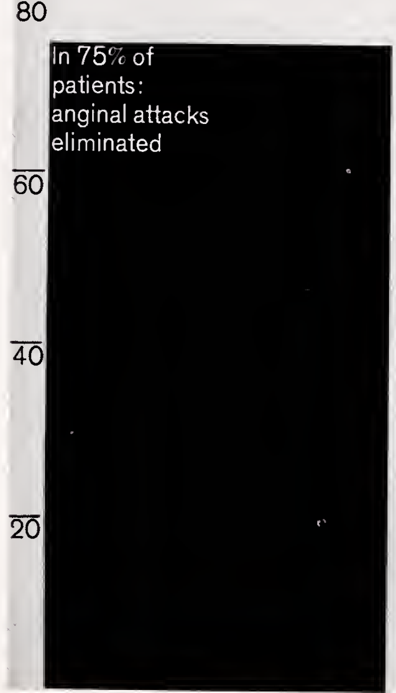

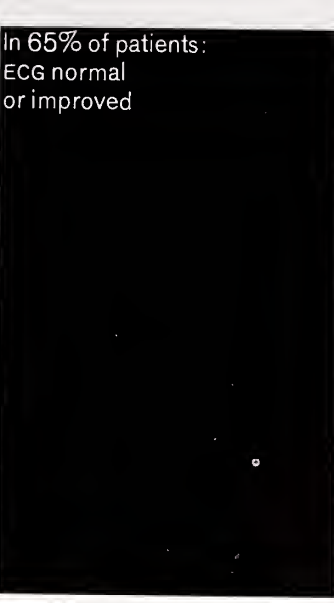

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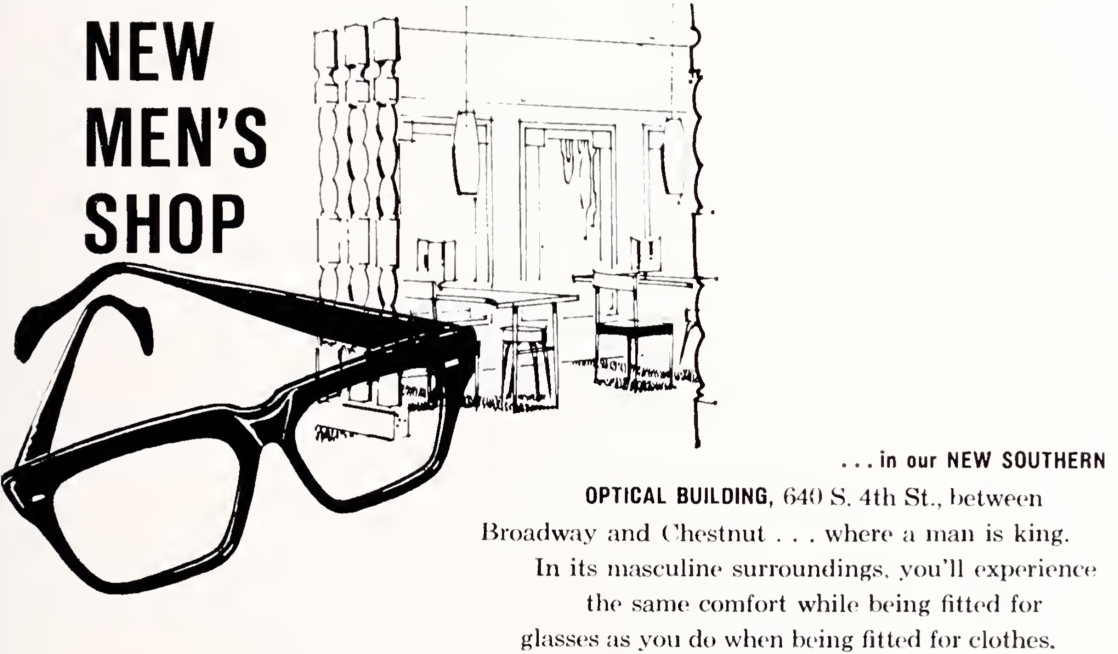

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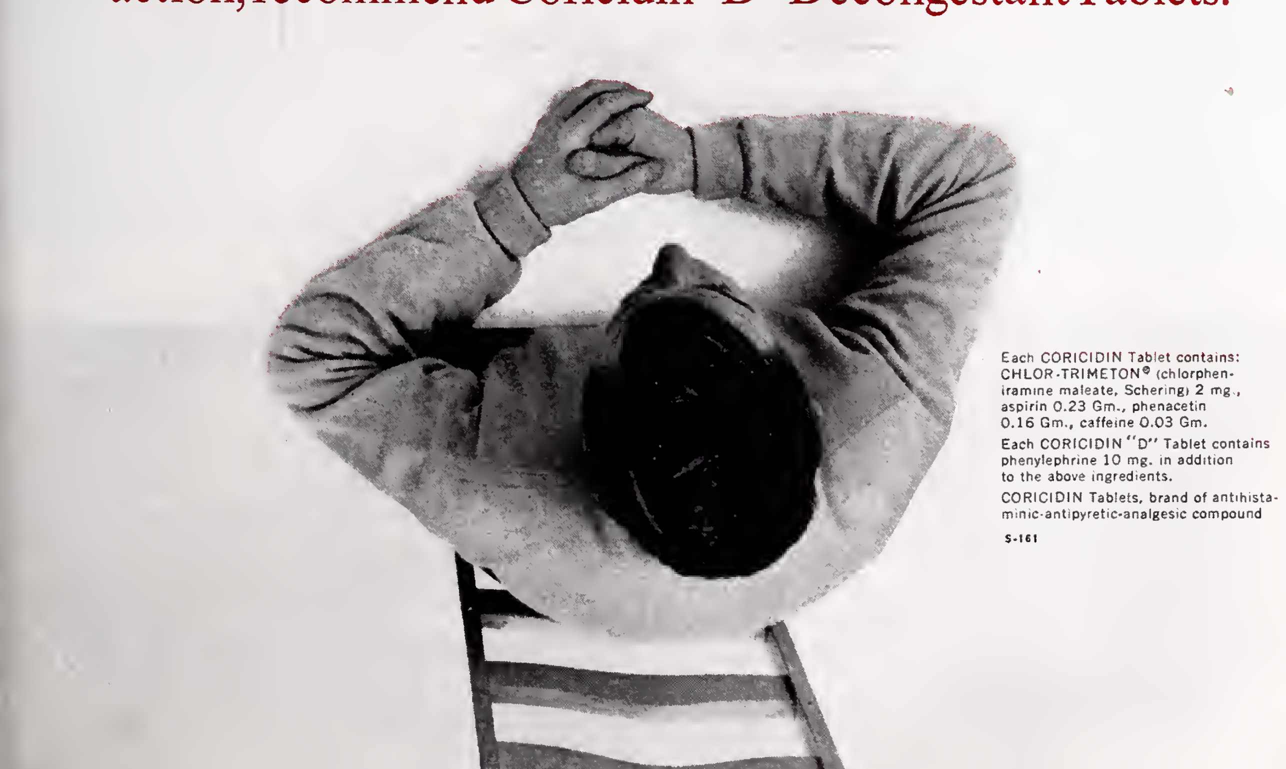

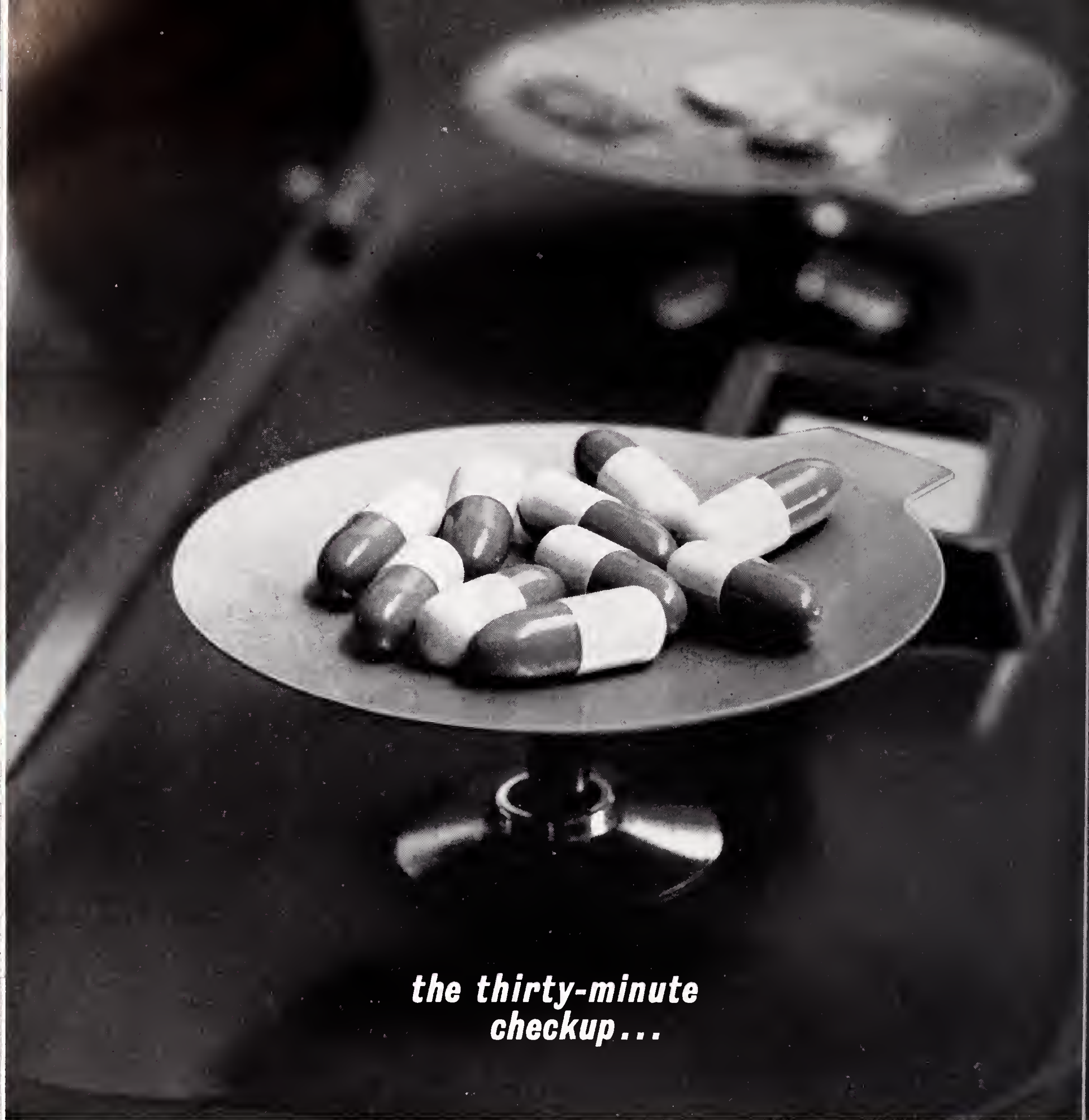

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Renal Homotransplantation

Gerald B. Reams, M.D.,* F.A.C.S.
Ashland, Ky.

In view of the recent success in prolonging skin homografts with pretreatment with Cytoxan, it was hoped that this agent might also be helpful in prolonging renal homografts. In this small series, however, it did not seem to have much effect.

SINCE recent advances in renal transplantation make this procedure more practicable, it is felt that every effort should be made to solve the remaining immunologic, physiologic and technical problems.[1]

Much of the basic information concerning the homograft problem has been accumulated slowly[2] from human kidney transplantation studies.[3] Four factors facilitate such studies: 1. A normal human can survive quite well with one kidney; 2. The uremia which would necessitate such a transplant tends to favor a prolonged graft survival; 3. Technically, the blood supply to the kidney can be instantaneously established by surgical anastomosis; 4. The fate of the transplant can be followed closely with urine and blood studies.

Carrell, Guthrie[4] and Allman[5] pioneered the technics of renal autograft, homograft and heterograft transplantation. Simonson[6], Dempster,[7] and Hume[8] added to the knowledge of the technic involved, and first described the histologic appearance of the rejected kidneys. Merrill and his associates in 1956[9] proved the practicality of renal transplantation when they transplanted a kidney from a healthy 24-year-old male to his identical twin who was then terminally ill with chronic glomerulonephritis. The kidney functioned well and has continued to do so up to the present day with the recipient's two diseased kidneys removed three months after the original surgery because of persistent hypertension. Up to this time, there have been nineteen[10, 11] successful reported cases of kidney transplants between identical twins. There have been several renal homografts with prolonged survival in animals treated either with total body irradiation[12] or with the antimetabolite mercaptopurine[13, 14, 15] which was first shown by Schwartz and Dameshek[16, 17] to cause a marked suppression of the antibody response when given simultaneously with the antigen. Hamburger and associates[18] in Paris have transplanted kidneys from close relatives to six patients with chronic renal insufficiency. These patients were treated with irradiation of between 430 to 460 rads in an attempt to inhibit the graft rejection response. Of these, three were successful, one for four months, and the other two are living and well at present, one a year post transplantation and the other two and one-half years post transplantation. It is their feeling that rejection of the renal homotransplant is not an all or none phenomenon but is a quantative immunologic reaction which, if it can be depressed sufficiently, allows a

*At time of writing, director of Animal Research Laboratory at the United States Air Force Hospital at Keesler Air Force Base, Miss.

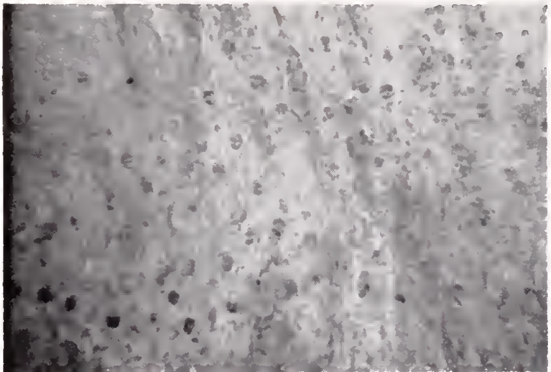

Figure 1. Renal Homograft in untreated dog, postoperative day 14. (25x)

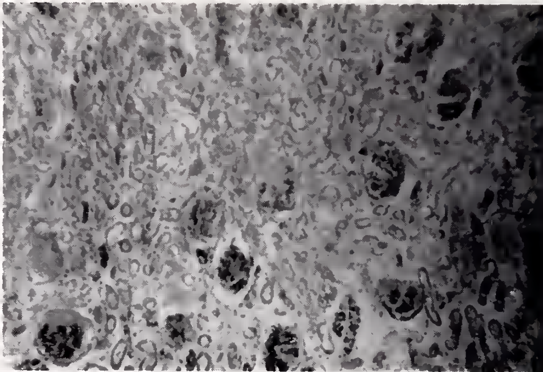

Figure 2. Renal homograft in untreated dog, postoperative day 14. (43x)

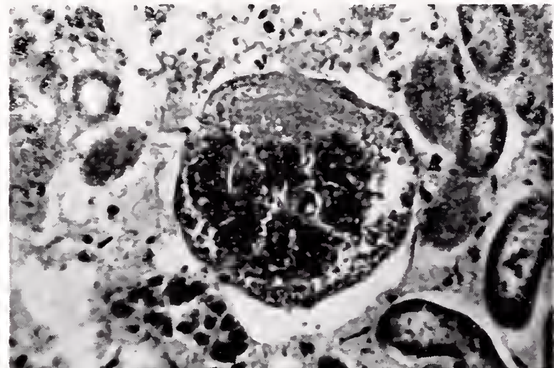

Figure 3. Renal homograft in untreated dog, postoperative day 14. (43x)

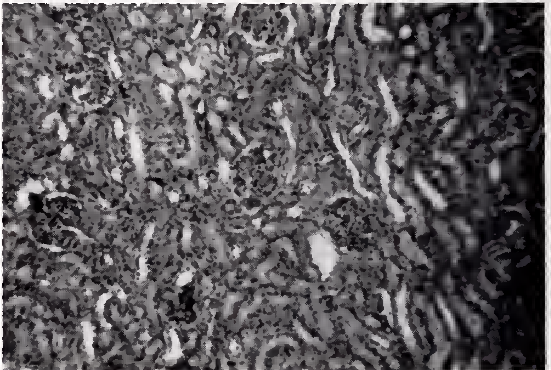

Figure 4. Renal homograft in cytoxan treated dog, postoperative day 14. (43x)

steady state of renal function to be achieved and maintained for years.

It was with the hope of finding some agent which would contribute to this depression that the following study was begun. An attempt was made to evaluate the use of a cytoxic agent, cyclophosphamide (Cytoxan), as the depressive agent. The agent was chosen because Sutton[19] has reported that skin homografts in mice could be prolonged by the administration of cyclophosphamide and Henegar, Jackson and Preston[20] have found that this drug used as a preconditioning agent permits an increased survival of tumor transplants in rats.

Experimental Study

A comparative study was done to evaluate Cytoxan depression of homograft rejection. Twelve mongrel dogs were used in the control series. They underwent bilateral nephrectomies and were recipients of a renal homograft from a similar type unrelated dog, usually of the same sex. The renal artery and the vein of the donor kidney were anastomosed end to end to the iliac artery and vein of the recipient and the ureter was anastomosed to the bladder. This was accomplished according to the technic originally described by Carrell[21] in 1911 and modified by Murray[22] and his associates in 1956. Eleven dogs survived the operative procedure and lived for a period averaging 12 days with a range between 7 and 15 days. The BUN increased on an average very precipitously about the seventh day and serial needle biopsies, taken three times weekly, showed an intense cellular inflammation of lymphocytes, plasma cells and macrophages beginning at about this time. The white blood count and hematocrit remained at almost the pre-operative level until this time and then fell. Representative microscopic sections of the transplanted kidney, at the time of autopsy, showing the cellular necrosis are shown in Figures 1, 2, and 3.

In the cyclophosphamide treated group, 5 mg/kg of the drug was given intravenously at the time of surgery and 10 mg/kg of body weight was given orally every other day beginning on the first post-operative day and continuing until death. Table 2 summarizes the

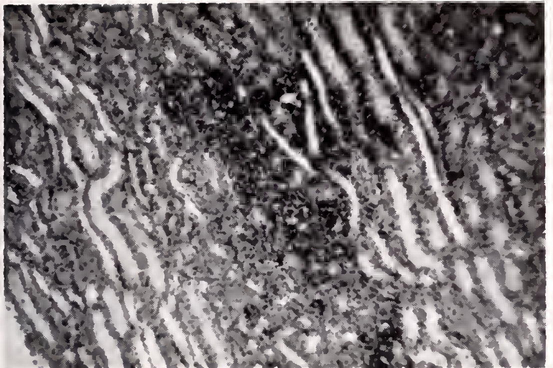

Figure 5. Renal homograft in cytoxan treated dog, post-operative 14. (105x)

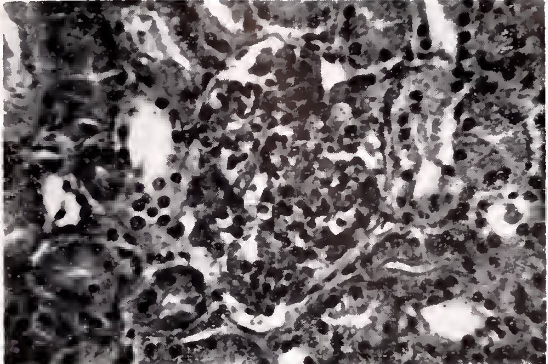

Figure 6. Renal Homograft in cytoxan treated dog, post-operative day 14. (430x)

TABLE I
RENAL HOMOGRAFT—CONTROL SERIES (UNTREATED)

RECIPIENT	SURVIVAL TIME (DAYS)	INCREASING BUN	DAY OF APPEARANCE CELLULAR INFILTRATE	DECREASING WBC. HCT.
#2 -11 kg.	12	8	7	5
#1	Operative Death			
#4 -17 kg.	9	8	7	6
#3	6	2	4	2
#6 - 8 kg.	7	3	7	5
#5	8	4	2	7
#12-11 kg.	11	8	7	9
#11	13	10	7	8
#20-20 kg.	15	None	14	14
#19	9	4	7	4
#22-16 kg.	13	4	11	4
#21	11	7	9	8

TABLE 2
RENAL HOMOGRAFT — CYTOXAN TREATED

RECIPIENT	TOTAL DOSAGE	SURVIVAL TIME (DAYS)	INCREASING BUN	DAYS OF APPEARANCE CELLULAR INFILTRATE	DECREASING WBC. HCT.
#8 - 9 kg.	450 mg.	8	4	7	3
#7	1035 mg.	23	16	18	2
#10-24 kg.	1300 mg.	12	8	9	4
#9	2040 mg.	17	13	14	4
#14- 7 kg.	400 mg.	4	3	4	1
#13	35 mg.	Operative Death			
#16-11 kg.	225 mg.	4	3	4	2
#15	1265 mg.	21	17	8	3
#18-24 kg.	1430 mg.	13	11	9	3
#17	1080 mg.	8	5	7	None
#24- 8 kg.	390 mg.	11	8	8	2
#23	520 mg.	11	7	6	4

findings in this group. There was one immediate post-operative death. The other animals lived an average of 12 days with a range from 4 to 23 days. Three animals exceeded the range of the control group, living 17, 21, and 23 days. Two animals died in 4 days (sooner than any of the controls) and had signs of drug toxicity. Outside of the last two, autopsy findings were similar in all cases with the kidneys markedly swollen and hemorrhagic. Representative microscopic sections are shown in Figures 4, 5 and 6. They show glomerular hemorrhage and infiltration of lymphocytes, plasma cells and macrophages. The lungs generally showed atelectatic changes and the liver sinusoids were engorged with red blood cells. The renal cellular infiltration and rising BUN appeared approximately 4 days (on the average) prior to the animal's death. The white counts post-operatively were depressed to about 1/3 the pre-operative level and the hemoglobin decreased approximately 30%. Both of these findings occurred during the first few days and afterwards generally remained at this level.

Summary

In view of the recent success reported in the prolongation of skin homografts and tumor transplants in animals treated with cyclophosphamide, it was hoped that this drug might be helpful in prolonging the survival of renal homografts. However, in this small study involving renal homografts in dogs in the dosage used, this agent did not seem to have a great deal of overall effect. Further study will be necessary to evaluate the prolonged response in three of the treated dogs.

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(Continued on Page 1166)

Drug Resistant Mycobacterial Infection And Its Response to Treatment†

ALEX SALIBA, M.D., F.C.C.P.,* AND OREN A. BEATTY, M.D., F.C.C.P.**

Louisville, Ky.

Various aspects of mycobacterial resistance are discussed. Improved initial therapy may avoid this problem. Combinations of the newer antituberculous agents with surgery have helped a number of treatment failures.

TREATMENT failures make it clear that there is much room for improvement in the therapy of tuberculosis.[1] In our opinion it is unfortunate that some have stated that larger doses of streptomycin and isoniazid (INH) are indicated in far advanced disease only. Further, we do not agree that INH alone may suffice. A review of a Veteran's Administration study tends to disprove such statements.[2]

Bacillary drug resistance may be demonstrated by the number of colonies observed on culture media containing known concentrations of antimicrobial agents. A growth equal to that in the control media (i. e. culture media without antimicrobial agents) would indicate a high degree of bacillary resistance to the drugs. Whether this reflects the therapeutic effects in vivo has long been a controversial matter, but most believe that one gives a fair indication of the other. Bacilli can be resistant to one or more of the currently available agents.

The defeat of tuberculosis has been predicted with increasing frequency since the advent of chemotherapy. Nevertheless, the morbidity around the world remains formidable, although the mortality in many countries is greatly reduced. Surveys for primary bacillary resistance in previously untreated cases have shown this to be on the increase. These patients presumably contracted their disease from others harbouring a drug resistant tuberculous infection. The serious import of such findings for the clinician and from the public health point of view has been stressed. We believe that adequate dosage of appropriate drugs, particularly in the initial period of treatment, can eliminate or greatly reduce the emergence of drug resistant organisms.

Raleigh[3] states that the view that inadequate treatment is better than no treatment should be condemned. Widespread infection by drug resistant bacilli is too high a price to pay for the transitory benefits from inadequate therapy. It has been suggested that the all too frequent practice of inadequate treatment in underdeveloped countries may eventually destroy what has been achieved so far in the control of tuberculosis, e.g.—last year an alarming increase in primary drug resistance was reported in E. Africa.

In a 1958 survey the International Union Against Tuberculosis[4] found primary drug resistance in 2.9% to 19% of 1400 patients in 17 countries. The incidence in the U. S. was above the average at 8.7%, whereas in 1957, a study by the Veteran's Administration Armed Forces reported an incidence of primary resistance in 5% and compared it with an earlier report of 2.5%. Primary resistance to all three drugs was rare, only five cases being recorded and all were in the U. S. In 1960 the New York City Health Department recorded an incidence of primary drug resistance of 13.8%, which was a marked increase from a report in 1955 when it was 6.5%. A 1960 study in England and Wales turned up an incidence of primary resistance of 5.0% with only a slight increase in INH resistance compared with a study in 1956. The use of daily streptomycin (SM) in initial treatment is customary there, which may explain this lower incidence. In contrast, the use of conventional doses of INH and para-aminosalicylic acid (PAS) with or without intermit-

†*Presented at the meeting of the Kentucky Thoracic Society at Lexington in October, 1961.*

**Hospital Director, District Two State Tuberculosis Hospital, Louisville, Ky.*

***Hospital Director, Richland Hospital, Mansfield, Ohio.*

tent streptomycin has been quite prevalent in the U. S. in initial treatment.

Drug resistance in tubercle bacilli presents in various ways:

(a) Primary drug resistance in a newly diagnosed case infected with typical tubercle bacilli and without previous treatment.

(b) Secondary resistance, which emerges in a patient with a previous susceptible strain of bacilli, presumably because of inadequate therapy.

(c) That resistance which is characteristic of some atypical mycobacteria (e.g. Photochromogens).

Concepts Of Bacillary Drug Resistance

Investigators at the National Jewish Hospital, Denver, have studied the problem of resistant mutants[5] and have estimated that approximately one in 10,000 bacilli is inherently resistant to INH and one in 1,000,000 is resistant to SM. About one in ten billion may be expected to exhibit primary resistance to both INH and SM. We agree with these authors that adequate dosage and combination of drugs would ensure greater success in treatment whereas inadequate dosage permits the emergence of resistant mutants.

If one drug is given in concentration enough to kill all susceptible organisms, but the other drug or drugs are not given in sterilizing quantities, then the bacteria which were resistant to the first drug persist. At first these bacteria might be too few to be found in the sputum, but given time, patients so treated would again be sputum positive and drug resistant.

Sweany[6] suggests the probability that aberrant forms of tubercle bacilli are the result of mutations which may have been increased by such factors as antibiotics, x-rays, ultraviolet light and so on. He stresses the importance of adequate therapy to prevent the emergence and natural selection of drug resistant mutants.

Antimicrobial Agents

The original three antituberculous drugs, isoniazid, streptomycin and para-aminosalicylic acid are still the most effective. INH is commonly used in a dosage of 300 mgs. daily, but there is evidence to suggest that in a substantial number of cases rapid inactivation may result in treatment failures. It is believed by some that a higher dosage, possibly adjusted to the serum level, would ensure greater success. In regard to streptomycin, there is general agreement here and abroad, that 1 gm, daily or 20 mg/kilo of body weight per day is adequate. PAS has been useful as an antituberculous agent per se, but probably more important is the fact that it has been shown to raise the serum level of active isoniazid by competing for the acetylation mechanism which is thought to inactivate isoniazid.

In the presence of established treatment failure, numerous other agents have been tried, and as a point of interest, one might mention that some studies in the past have proved that high doses of vitamin C exerted a bacteriostatic and bactericidal influence on tubercle bacilli in vitro. A study at this hospital[7] confirmed the suppression effect of vitamin C on culture growth at six weeks in comparison with controls. This effect cannot be reproduced in vivo, probably because of rapid excretion.

Some of the more important secondary drugs are the following:

Cycloserine, derived from Streptomyces orchidaceus, is commonly used in a dose of 250 mg. twice daily. It has also been used in a dosage of 1 gm. daily and higher, with a corresponding increase in neurotoxicity, particularly psychotic reactions and convulsions, which occur more readily in persons with a history of neuropsychiatric disorders.

Pyrazinamide (PZA) is a synthetic antituberculous agent more commonly used in a dose of 500 mg. t.i.d., but as much as 3 gm. daily has been given. With the higher dosage the incidence of severe liver damage with jaundice increased.

Viomycin, derived from Streptomyces puniceus, is usually used in a dose of 1 gm. twice a day, two days per week. It exhibits high toxicity, both auditory and renal. There is no cross resistance with streptomycin.

Kanamycin, isolated from Streptomyces kanamyceticus in 1957 by Umezawa, has been found useful in a number of organisms besides M. tuberculosis, including drug resistant strains, and anonymous mycobacteria. In vitro and animal experiments have demonstrated its antituberculous effect, which is inferior to INH and streptomycin. There is cross resistance with neomycin and viomycin but none with streptomycin, INH or PAS. It is given I.M., 1 gm. daily for four to five days per week, or 1 gm. b.i.d. two days per week. Less than 4 gm. per

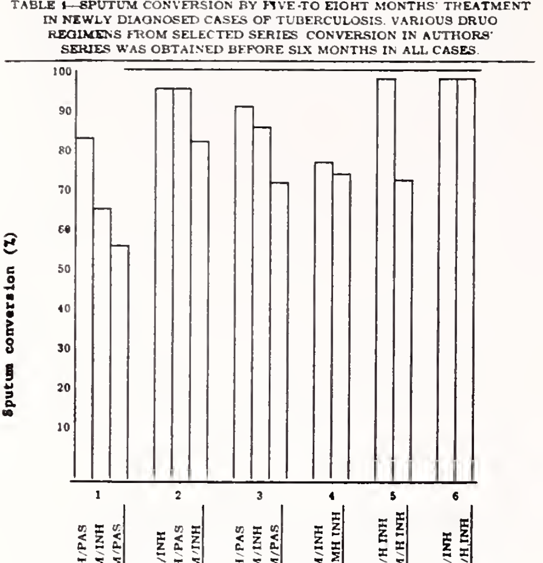

TABLE 1—SPUTUM CONVERSION BY FIVE-TO EIGHT MONTHS' TREATMENT IN NEWLY DIAGNOSED CASES OF TUBERCULOSIS. VARIOUS DRUG REGIMENS FROM SELECTED SERIES CONVERSION IN AUTHORS' SERIES WAS OBTAINED BEFORE SIX MONTHS IN ALL CASES.

1. Veterans Administration.
2. British Medical Research Council.
3. U.S. Public Health Service.
4. Series by Biehl (Vide Refs.)
5. National Jewish Hosp., Denver.
6. Authors' Series

INH/PAS - daily INH with PAS, conventional doses.
SM - daily streptomycin, 1 gm.
2SM - intermittent streptomycin, usually 1 gm. twice weekly, sometimes 3 times weekly.
H.INH - high dosage of isoniazid at least 12 to 16 mgm. per kilo. or higher, given daily in divided doses.

Reproduced from Acta Tub. Scand., 40,114,1961 and Dis. Chest, 40,259, 1961.

week has a poor therapeutic effect, and 6 gm. or more per week results in a definite increase in the incidence of deafness. Because of the seriousness of renal and auditory toxicity, it should be reserved for resistant cases or, in some cases, as a surgical cover. Resistance to kanamycin develops as it does to other agents.

Other drugs have been tried in resistant tuberculous infection. The tetracyclines in a dose of 4 gm. per day have been used with other anti-tuberculous drugs with some benefit. A smaller dose was found ineffective. The gastrointestinal disturbances from such a dose makes this of limited value.

Brouet, et al,[8] reported a study of another synthetic compound, Alpha-ethyl-thioisonicotinamide (Ethionamide), which apparently exhibited no cross resistance with INH. They used this in a dosage of 1 gm. daily by mouth, with viomycin and/or cycloserine. Twenty-eight chronic, resistant cases were treated, with sputum conversion in about 75% and varying degrees of radiographic improvement. The main side effects consisted of neurotoxicity and gastrointestinal disturbances. A follow-up on these cases was not presented. In a recent issue of Tubercle[9] there is a report by the Research Committee of the British Tuberculosis Association dealing with this same agent combined with pyrazinamide or cycloserine in previously treated patients. A dose of 1 gm. per day resulted in numerous side effects so this was reduced to 0.5 gm. per day but even so, many cases were withdrawn from trial. Of those left at six months, 50% had become negative by culture. Gastrointestinal disturbance and hepatotoxicity were more common in combination with PZA, but psychotic reactions were more frequent when used with cycloserine.

Neomycin, another antibiotic, was found effective in animal experiments but its high degree of toxicity in the required dosage precluded its use in tuberculous patients. Thiocarbanidin was another drug considered promising but withdrawn because of toxicity.

Schwartz[10] reported a Veteran's Administration Armed Forces study of kanamycin alone and combined with PAS or tetracycline in 75 previously treated patients. After six months of therapy there was practically no conversion by culture and deafness was observed in 39%.

A study from Denver[11] dealt with three groups of resistant patients: The first consisted of 171 cases retreated with high doses of INH and SM, with and without PAS. The salvage rate, that is, patients whose sputum became negative and patients who became suitable candidates for surgery, was 23%, with 77% failures. The second group (47 patients) was treated with pyrazinamide 500 mg. t.i.d. plus cycloserine 250 mg. b.i.d. plus high doses of INH with and without kanamycin. The addition of kanamycin did not appear to improve results in such a regimen and toxicity was higher. The overall salvage rate, including those prepared for surgery, was 64%. In the third and much smaller group (18 patients) higher doses of cycloserine and PZA were used and this was found superior to a combination of kanamycin with PZA. There was a salvage rate of 87%. Routine observations were made for liver and kidney damage, 8th nerve involvement and psychotic changes. Pyridoxine 300 mg., meprobamate 800-1200 mg., and chlorpromazine were used to counteract some of the toxic manifestations. The incidence of toxicity in the second and third groups was 50%.

Pyle and associates,[12] using cycloserine 1.5 to 2.5 gm. per day, had to discontinue treat-

ment in 10% of 50 patients because of reactions. Ritchie et al,[13] observed involuntary tremors in more than half of their patients on the lower dose of cycloserine. Bachman et al,[14] treated 84 chronic cases with INH and cycloserine with a sputum conversion rate of 14%. Toguri and Atwell,[15] reported sputum conversion in 45% of 20 cases treated with cycloserine and PZA. Schwartz and Moyer,[16] noted a very small number of conversions in 71 patients retreated with cycloserine and viomycin. McLean et al,[17] used PZA and viomycin in retreatment cases with sputum conversion in about 55%, but with high toxicity.

On the other hand there is no evidence that as original therapy, any of these regimens is superior to daily streptomycin and isoniazid or isoniazid and PAS. Matthews[18] does not recommend PZA in original treatment because of toxicity. Epstein has demonstrated the effect of pyridoxine in the control of some of the toxic reactions to cycloserine and has also noted that most of these reactions occurred in psychotic and epileptic individuals.[19, 20]

Present Study

Twenty-six patients, mostly with far advanced cavitary disease and classified as treatment failures were studied.[21] All had received many months of chemotherapy and some had had surgery. Sputum was positive by culture in all cases prior to change in treatment. They were placed on cycloserine, pyrazinamide and high doses of isoniazid (16 mg./kilo) for a period of at least three months. Sputum conversion was obtained in 30% of this group, but two patients are known to have suffered a bacterial relapse. Another smaller group (15 patients) also with mostly far advanced disease was retreated with SM and high doses of INH with and without PAS and had a sputum conversion of 66%. One of these patients has had a bacterial relapse since. In the group retreated with SM and INH in larger doses, the patients appear to have done better but it is noteworthy that in this group the history of disease was shorter, as was the duration of previous therapy. No patient in either group had received initial treatment with daily SM or high dosage INH; and 22 of both groups of patients had persistently positive catalase reactions after months of therapy, suggesting the inadequacy of the previous INH dosage. The majority of those whose sputum converted (both groups) had a positive catalase test. Psychotic reactions to the combination of high INH and cycloserine were significant (15%), possibly because our dosage of pyridoxine was limited to 100 mg. daily during this study. Wolinsky and Kapur (22) reported a similar experience with the same combination of drugs.

Anonymous Mycobacteria

The problem of treatment of infections due to anonymous mycobacteria is not solved, and kanamycin may be worth a trial. These bacilli are so often resistant to all the standard antituberculous and other agents that multiple drug therapy, with surgery at the appropriate time, may be necessary. Sputum conversion and radiological improvement on chemotherapy alone are often disappointing. These infections appear to be worldwide in distribution, they demonstrate low pathogenicity for the guinea pig, some have a high catalase activity, and some produce a yellow pigment on culture and exposure to light. Contact infection has not yet been proved but transmissibility of the infection cannot be excluded. In some patients M. tuberculosis was isolated either prior to or concomitant with the anonymous mycobacteria. Lewis et al,[23] reporting on surgery for cavitation in 25 patients infected with anonymous mycobacteria, stated that seven continued to excrete bacilli, five developed complications and one died.

Management

It is obvious that if the number of patients with drug resistant tuberculous infections increases, this will constitute a serious public health problem. We lack adequate treatment for such patients.

From the foregoing review of therapy in drug resistant cases we conclude that the combination of cycloserine with pyrazinamide is probably the best regimen currently available. Isoniazid should also be used and the addition of pyridoxine minimizes toxicity from INH and cycloserine. Increase in doses of cycloserine to 1 gm. daily or more, and of PZA to about 3 grams per day have produced better results and may be worth a trial under careful observation, keeping in mind the high toxicity. For those patients with a recent history of disease and chemotherapy of less than one year, daily streptomycin with high dosage isoniazid is certainly

worth a trial, particularly if the catalase reaction is positive. Kanamycin should not be used in preference to PZA and cycloserine because of its higher toxicity, but as a short term extra cover for surgical procedures it may be of some benefit. These secondary drugs should not be used singly. Drug susceptibility studies and serum assays are now available for most of these agents. A number of patients may thus be salvaged, by which is meant sputum conversion or sufficient improvement to make surgery feasible.

Although corticosteroids are indicated, and indeed beneficial, in selected cases of tuberculosis, there is evidence of gross increase of disease when they are used in drug resistant infections. One must use these agents under cover of adequate chemotherapy in the presence of drug susceptible bacilli. In a terminal case any risk may possibly be justified, but by and large, corticosteroids are to be avoided when a drug resistant tuberculous infection has been diagnosed.

Surgery has a higher morbidity in the presence of positive sputum but it is necessary in such otherwise hopeless cases. When feasible it should be done within two to three months of the start of a new therapy regimen, to benefit from the maximum effect of the chemotherapeutic agents. Many of these patients are often poor surgical risks, so the procedure which least impairs their pulmonary function is the procedure of choice. Pneumothorax and pneumoperitoneum no longer enjoy popularity, but may be useful in selected cases harbouring such infections.

Finally, because of our inability to deal effectively with tuberculous infections resistant to our current antimicrobial agents, our efforts should be directed to the prevention of treatment failure through the better use of streptomycin, isoniazid and PAS, particularly in the initial period of treatment, the first six months being the most important.

Summary

The management of drug resistant mycobacterial infection is discussed. This resistance can be primary or secondary.

Of the various agents available for the treatment of resistant infection, cycloserine and pyrazinamide appear to offer the most promise, although daily streptomycin and high isoniazid dosage may be a useful combination in specific retreatment cases. The importance of avoiding treatment failure through adequate initial therapy in newly diagnosed cases is emphasized.

Addendum

Since presentation of this paper two years ago there has been no major change in the management of drug resistant mycobacterial infection. However three other secondary drugs are receiving experimental trials: Ethambutol, Isoxyl, Capreomycin. A paper on this subject presented at the Am. College of Chest Physicians Convention, June 1963 indicated that four or five of these secondary drugs should probably be used simultaneously. In this way sputum conversion can increase to 82%, although the frequency of toxic reactions from such combinations may limit their use. Prevention of treatment failures is therefore of utmost importance.

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A 47-Pound Solid Retroperitoneal Myoma of the Uterus

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A very large myoma of the uterus grew into the left broad ligament and far up behind the peritoneum. There was extensive parasitic blood supply which caused great blood loss during its excision.

IN 1923, Charles Farmer[4] reported in this Journal the successful removal of a 35-pound myoma of the uterus. The operation was difficult because the tumor was adherent to the peritoneum anteriorly. The patient made a satisfactory recovery. In 1924, M. Y. Marshall[10] also reported in this Journal the successful removal of a uterine fibroma weighing 47 pounds. There were large omental veins, one to four inches in diameter, but there were no other adhesions. The growth was joined to the uterus by a pedicle, two by three inches across. The interior of the tumor showed cystic degeneration.

This is a third report of a large uterine tumor, a 47-pound retroperitoneal solid myoma, technically difficult to remove. Twenty-four units of blood were required for replacement of that lost during the operation.

Several larger tumors of the uterus have been described, most of which were cystic. Insufficient blood supply for the large tumors usually causes extensive cystic degeneration. Of those found at autopsy, or in cases in which removal was unsuccessful, Hunter[8] described a cystic tumor which weighed 140 pounds; Stockard[6] had a fatal case with a tumor which weighed 135 pounds, and McIntyre[6] reported a tumor which weighed 106 pounds. Greenhill[7] described a cystic fibroid found at autopsy which weighed 47 pounds.

Webster,[13] in 1903, successfully removed a tumor which weighed 87 pounds. In 1907, T. S. Cullen[3] removed a cystic fibroid tumor which weighed 89 pounds. The tumor was rolled out into a wash tub covered with sterile sheets and held by four medical students. This patient recovered. This tumor has been retained as a specimen in the Army Medical Museum. Apparently this was the largest tumor successfully removed and reported in the literature. Eastman[3] had a successful case in which the tumor weighed 60 pounds.

In 1925, Stevens[11] removed a myoma weighing 47 pounds. Beacham and his associates,[2] in 1947, reported the successful removal of a 55-pound solid myoma from a 65-year-old woman. The operating time was 65 minutes. Stiefel and Cretsinger,[12] in 1949, removed a solid myoma from a 63-year-old Negro woman. The tumor weighed 74 pounds. Numerous adhesions were present which required tedious dissection. Two years later the patient was well.

Case Report

This 43-year-old white woman, seen in May, 1962, complained of a pelvic tumor for two years. This tumor had been observed by her family physician, and was known to be quite large and growing continuously. She had had dull abdominal discomfort for three days before menstrual periods. Three months before admission, pain appeared in the right thigh, and a

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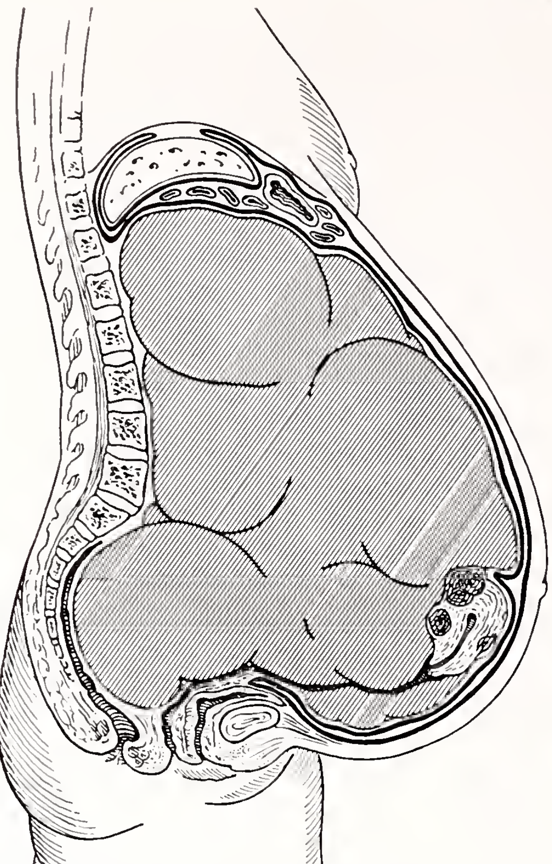

The illustration was prepared by the Department of Visual Education, University of Louisville School of Medicine.

Fig. 1. Diagrammatic illustration of the large multinodular retroperitoneal myomas of the uterus. Note the displacement of the posterior peritoneum to contact with the anterior peritoneum.

month later both legs began to swell. While pain was not a prominent complaint, the abdomen had become so large that she could hardly walk, was readily fatigued, and dyspneic. Her menstrual periods began at 13 years of age, occurred at 28 day intervals, with duration of four to eight days, moderate flow, no cramps, and no intermenstrual bleeding or discharge. She had had one child 24 years previously. Her weight was 185 pounds.

Six weeks prior to admission to the hospital, she had had exploratory laparotomy elsewhere, with the finding of a large abdominal tumor, at first thought to be malignant because it was fixed and retroperitoneal. The biopsy report was benign myoma. The surgeons felt that it was impossible to remove this tumor.

On examination, the abdomen was tremendously enlarged, quite firm, dull to percussion, except for some tympany in the right flank. The legs were greatly enlarged and edematous, although the arms were of normal size. The vulva was somewhat edematous. The vagina appeared normal. The cervix could not be palpated, as it was displaced very high by the tremendous, firm tumor which filled the true pelvis, seemed completely fixed, and rose to the xiphoid as a huge, protuberant tumor mass. Rectal examination was negative except for the pelvic tumor.

Under general anesthesia, a midline incision from the xiphoid to the symphysis revealed the large, firm, nodular tumor. This was the size of four term pregnancies or more. There was no free fluid. The tumor was adherent to the low midline incision where exploratory laparotomy had been performed recently. This proved to be the posterior peritoneum covering the tumor which was adhrent to the anterior wall in contact with the incision.

The liver and intestines were displaced under the diaphragm. The corpus of the uterus was three times normal size, contained several small myomas, and was displaced high on the large tumor mass to the right of the midline. The ovaries were enlarged, edematous, and situated in the mid-abdomen over the tumor. It was apparent that the tremendous lobulated tumor was retroperitoneal, and that it arose from the left side of the uterus and had extended originally into the left broad ligament, from which it grew beneath and behind the peritoneum into the very depth of the pelvis as one nodular mass, and retroperitoneally up under the liver as a great lobulated tumor.

The ovarian and round ligaments were divided and sutured. The peritoneum of the bladder reflection was incised at the level of the mid-abdomen, and the large, flattened bladder was displaced toward the symphysis pubis. This exposed the uterine vessels which extended anteriorly across the tumor. These were clamped, cut, and ligated. The vagina was entered, cut across, and the cervix was lifted out of the vagina. A lock stitch of chromic catgut suture was placed around the vaginal cuff. The posterior peritoneum was divided by a vertical incision over the tumor, and the stumps of the uterine vessels were pushed far laterally. Evidently this aided in displacing the ureters to the sides. The lobulated tumor was enucleated slowly and with great difficulty. There was profuse bleeding from numerous large veins and smaller arteries along the entire posterior surface. Many veins were clamped, cut, and ligated, but the bleeding often was excessive.

Manual dissection was made very close to the tumor to sweep the ureters to the sides and posteriorly.

It was necessary to stop the operative procedure while blood was being replaced on several occasions because of intermittent shock. After four hours, it was necessary to use great force for immediate extirpation of the remainder of the tumor. Many abdominal gauze pads were placed in the upper and lower abdomen, and gradually the veins and smaller arteries were secured by ligatures. A number of portions of Surgicel® gauze were packed in the depth of the pelvis to control oozing. The left ureter was distinguished, found quite elongated and moderately dilated, but the right was not visualized in the blood stained tissues.

Eventually, the posterior peritoneum was closed, as was the abdominal wall. Eight stay sutures were inserted. The operation required five and one-half hours. Twenty-two pints of blood were given during the operation, and two more in the recovery room. After a few hours of moderate shock, the patient stabilized and recovered without unusual difficulty. The following day she rallied and recovered rapidly. The blood report was as follows: Hemoglobin, 10.6 Gms. Red blood cell count, 3,550,000. White cell count, 12,500. Neutrophils, 86%.

One year after operation all swelling was absent from the legs, the abdominal wall was firm, and the patient felt extremely well.

The tumor masses were lobulated and were quite solid. They appeared to be ordinary fibromyomas of the uterus, and weighed 47 pounds. There were no cystic changes, evidently because the blood supply was more than ample to this retroperitoneal tumor. Microscopic study showed benign myomas, a large benign endometrial polyp, small areas of endometriosis in each ovary, and moderate chronic cervicitis.

Discussion

This case is unusual in that the tumor was located in a retroperitoneal position. Evidently it began as a small myoma which grew from the uterus between the leaves of the left broad ligament. Here it became parasitic and grew to a large lobulated mass which extended retroperitoneally from the depth of the pelvis up to the diaphragm. The superior mesenteric vessels remained in an elongated superior position while the inferior mesenteric vessels were posterior to the tumor. An extraordinary number of parasitic vessels had formed to enter this tumor on the posterior and lateral surfaces.

The blood loss frequently was profuse during the operation. Often blood was administered under pressure to restore blood volume. It was fortunate the Red Cross Blood Bank could supply the 24 pints of type O, Rh-positive blood that was necessary. The anesthesiologist administered blood according to his estimate of blood loss. During the course of the operation, 150 laparotomy packs were used, the majority of which were saturated with blood, and a very considerable amount of blood was removed by suction.

During the early phase of the operative procedure, it was patently clear that the successful extirpation of this huge tumor would require massive blood transfusions; therefore, the patient was digitalized with intermittent doses of 0.4 mg. of Cedilanid® intravenously. We were also concerned about the high potassium content of the large amount of bank blood to be transfused. The addition of this potassium is reported not to be a causative factor in producing abnormally high serum potassium levels, but hypoxia from low perfusion pressure and hypovolemia does cause the release of epinephrine and large amounts of potassium from the liver, which may produce dangerously high serum potassium levels. For this reason, 10 units of regular insulin and dextrose, 1 Gm. per 500 cc. of blood, was administered in order to "trap" potassium in the liver.

It was obvious the patient's temperature was subnormal, and to monitor this, an esophageal lead was introduced into the mid-esophagus. At the end of three and one-half hours of operative procedure, the patient's temperature was 91 degrees Fahrenheit, which is mild hypothermia. This undoubtedly reduced the oxygen requirements by reducing metabolism, but also increased the risk of acidosis, particularly during the rewarming period. Tham® (Tromethamine, Abbott [Tris (Hydroxymethyl) aminomethane] investigational), an amine buffer, was administered 1 Gm. per kilogram intravenously, along with 6 molar sodium lactate to buffer the release of acid metabolites and prevent any shift in the blood pH.

The patient's fibrin index was 160 seconds near the end of the operation; 7.7 Gms. of fibrinogen were administered intravenously, and

this corrected the fibrin index to ten seconds. Four units of fresh blood were administered at the conclusion of the operation, and in the immediate postoperative period. The prothrombin time, which was likewise low during the late operative period (32 per cent of normal), was corrected with protamine sulfate 1 Gm. intravenously. Calcium gluconate, 2 Gms. was administered intravenously during the operation. Dextran 1000 cc. was administered while waiting the delivery of additional blood.

The continuous loss of large quantities of blood via suction, sponges, etc., required close attention in the estimation and measurement of blood loss and prompt replacement through two 15-gauge intravenous needles. At the conclusion, it was estimated the patient had lost 9,550 cc. of blood, and that 8,800 cc. had been replaced to that point. A complete blood count revealed the venous hematocrit, hemoglobin and red blood cell count to reflect this deficit of 750 cc. blood as compared to the preoperative complete blood count.

While we have used more than 50 pints of blood in two other cases in the post-hysterectomy period of six to eight weeks because of hemorrhage due to blood dyscrasias, this case with 24 pints administered continuously in one day, with recovery of the patient, seemed unusual. But Gardner and associates[5] reported 58 transfusions in connection with a case of placenta percreta in which control of bleeding was finally accomplished after the application of pneumatic pressure to the lower half of the body. Artz and associates[1] reported a battle casualty to whom 23,350 cc. of blood was administered within 24 hours. Marchant and Hobika[9] (1959) gave 95 transfusions to a patient who had an anterior exenteration for endometrial stromal sarcoma. Their patient survived.

Summary

A case of successful removal of a solid, 47 pound retroperitoneal myoma of the uterus is reported. Twenty-four pints of blood were required to replace the blood loss. It was fortunate that the patient did not develop jaundice nor urinary suppression during her hospitalization, and one year later, is healthy and leading a normal life.

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Plan Now

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1964 KSMA Interim Meeting

Jenny Wiley State Park **April 23, 1964**

Physiological Changes in Pulmonary Emphysema

DOUGLAS DAVID, M.D.*
Louisville, Ky.

In order to treat the patient intelligently one should understand the physiological changes responsible for his disability.

RESEARCH during the last decade in the anatomic, physiologic and clinical features of pulmonary emphysema has brought an increased interest in and need for a more satisfactory explanation of physiological changes. This is difficult, when the same thing is called by different names or different things by the same name. Also, to add to the confusion, the clinician may call the entity "senile emphysema," chronic obstructive pulmonary emphysema. The radiologist may interpret a film as showing pulmonary emphysema when in reality there is no pulmonary defect, and a patient with chronic obstructive pulmonary emphysema can be fully incapacitated despite very little roentgenographic evidence of disability.

The disease itself is complex, so many different factors combining in such differing proportions, and so variable from one part of the lung to another. Hyperfunctioning, normal functioning, hypofunctioning and nonfunctioning lung structures co-exist side by side physiologically dependent on each other. Consequently, it is becoming evident that structure and function are intimately related and a truly complete analysis of one must include a detailed evaluation of the other. Also, it should be kept in mind that a physiological description of the patient's disease, or an anatomic description, no matter how complete, will provide only a momentary view of the disease. However, physiologic laboratory studies are essential in diagnosing chronic obstructive pulmonary emphysema.

Respiratory Work

During breathing, the respiratory muscles must move the chest wall (chest cage, diaphragm, abdominal contents displaced by the diaphragm), the lungs, and the gas in the respiratory tract. In accomplishing this movement the respiratory muscles must overcome: (1) the elastic properties of the lungs and chest wall, and (2) the flow-resistive properties of the lungs and chest wall. The flow-resistive properties include the viscous resistance offered by the lung and chest wall tissue and the gas flow-resistance within the air passages.

When the flow-resistive work exceeds the elastic work, expiration cannot be accomplished passively by the stored elastic energy alone, and expiratory muscles assist during expiration. Therefore, either a decrease in elastic recoil or an increase in mechanical resistance (resistance to deformation) can lead to active expiration.

Changes in the visco-elastic properties of the lung and progressive bronchial narrowing are the prominent features in the pathophysiology of chronic pulmonary emphysema.[1] These changes first affect the ventilatory function of the lungs. The determination of vital capacity (measure of elastic properties of the lungs and chest wall), may be either normal or reduced.

†*Presented at the September 18, 1962 meeting of the Kentucky Chapter, American College of Chest Physicians, during the Annual Meeting of the Kentucky State Medical Association.*

**Instructor in Medicine at the University of Louisville School of Medicine, Louisville, Ky., and Director, Cardiopulmonary Laboratory and Chief of Pulmonary Division, Saint Joseph Infirmary, Louisville, Kentucky. Acting-Chief, Pulmonary Function Laboratory, Veterans Administration Hospital, Louisville, Kentucky.*

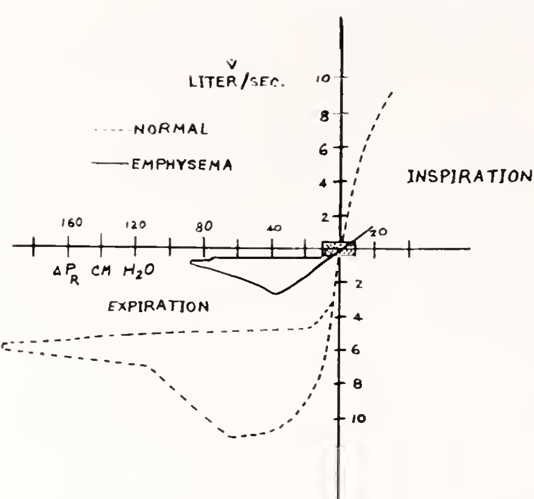

Fig. 1. Resistive pressure-flow graphs during maximally rapid inspirations and expirations for a normal (dotted line) and a patient (solid line). The flow-resistive pressure difference is on the abscissa and the rate of flow is on the ordinate.

Maximal breathing capacity, maximal expiratory flow rate and timed vital capacity (measure of flow-resistive abnormality) are decreased. The respiratory minute volume is increased.

As a result of the chronic hyperinflation of the lung, the total lung capacity is slightly larger than normal. Because of the airway obstruction it is impossible for these patients to empty their lungs normally, so that the amount of air left in the lungs at the end of a forced expiration (the residual volume) is greatly increased. Since the degree of obstruction of the airways is not the same in all portions of the lung, there is unequal expansion of the various parts of the lungs, leading to non-uniform distribution of inspired air.

The higher the respiratory rate, the more marked the unequal ventilation. This is revealed in the seven-minute nitrogen wash-out test or by the helium mixing curves. These studies do not take into account the forces involved during the particular ventilatory process. Furthermore, there usually are basic differences in the mechanics of breathing during quiet respiration and during maximal ventilatory efforts in patients with chronic pulmonary emphysema. Therefore, the results of routine pulmonary function tests do not always correlate well with the degree of actual functional impairment.

The elastic properties of the lungs can be expressed as compliance which is defined as the volume change per unit of pressure change (liters per cm. H_2O). A low compliance characterizes a stiff lung (difficult to distend); and a high compliance, an easily distensible lung. The decrease in compliance found in patients with pulmonary emphysema becomes extremely unfavorable during expiration. In the normal lung, the elastic forces of the alveoli tend to keep the airways patent against the positive intrapulmonary pressure during the expiratory phase. If these elastic forces are decreased, their tension becomes insufficient and the pathological airways collapse during expiration (ball valving). The marked increase in expiratory flow resistance over inspiratory flow resistance is in part due to ball valving and the fact that the caliber of the airways is a function of lung volume. As expiration proceeds, higher and higher pressures are required to move the air out of the lungs at a minimal flow rate (Figure 1.)[2]

While the expiratory work (work equals pressure times volume) is less than the elastic work for the normal subject, it is considerably greater in patients with chronic pulmonary emphysema. The respiratory work may be increased to such an extent that most of the energy expenditure goes into respiration alone, thereby depriving the patient of any energy necessary for even slight physical work.

There is a relationship between the mechanical work of breathing and the rate and depth at which a person breathes. For any given alveolar ventilation there is an optimum respiratory rate and tidal volume during which the total mechanical work of breathing is decreased. Both normal subjects and patients with respiratory disease breathe at a rate and depth at which the work of breathing is minimal.

Ventilation

In patients with pulmonary emphysema the oxygen consumption of the respiratory muscles rises sharply with increasing ventilation.[3] Because of the high metabolic cost of breathing, the carbon dioxide production is proportionately higher than the increase in alveolar ventilation. Therefore, an increase in respiratory minute ventilation would lead to a further elevation of the respiratory work and a possible rise in arterial carbon dioxide tension.

Injection studies of the pulmonary vessels and arterial gas studies during nitrogen wash-

out[4] suggest that the circulation of blood is uneven in the emphysematous lung. As stated previously, there is uneven ventilation in various parts of the lungs. An imbalance in ventilation-perfusion relationships is therefore a characteristic physiological finding in pulmonary emphysema.[5, 6]

In normal subjects the ventilation-perfusion ratio is normal for both the well and the poorly ventilated regions of the lung. The perfusion of poorly ventilated alveoli results in arterial hypoxia. Differences in the dissociation curves for oxygen and for carbon dioxide initially allows the hyperventilated alveoli to compensate for the inadequate output of carbon dioxide from the hypoventilated alveoli without correcting the arterial hypoxia. The ability of oxygen to diffuse across the alveolar-capillary membrane is reduced in chronic obstructive pulmonary emphysema, particularly in its later stages, which some think is because of the reduction in the size of the total alveolar-capillary surface area. Briscoe[6] states that variations in the ventilation-perfusion relations could give a variety of alterations in diffusion. This fits with the increase of diffusing capacity which is seen as the patient improves clinically.

Alveolar hypoventilation is a relatively common occurence in patients with pulmonary emphysema. Consequently, the arterial carbon dioxide tension is elevated, pH is low and bicarbonate content is high. Of course, one should keep in mind the carbon dioxide combining power may be normal or relatively low in respiratory acidosis if metabolic acidosis is also present. Thus, given a patient with a mixed acidosis the clinician may find a normal carbon dioxide content and a greatly elevated carbon dioxide tension. Also, it should be emphasized that patients in respiratory acidosis may have an elevated pH, hypochloremia and/or hypokalemia. Because patients with arterial hypercapnia do not increase their ventilation in a normal manner when breathing carbon dioxide, it is thought that the sensitivity of the respiratory center is diminished. Alexander et al[7] concluded that chronic hypercapnia per se results in a diminshed sensitivity to the carbon dioxide inhalation stimulus. When the medullary respiratory center loses its ability to respond to excessive levels of carbon dioxide, the only remaining stimulus to respiration is the hypoxia. This factor becomes extremely important when oxygen therapy is given.[8]

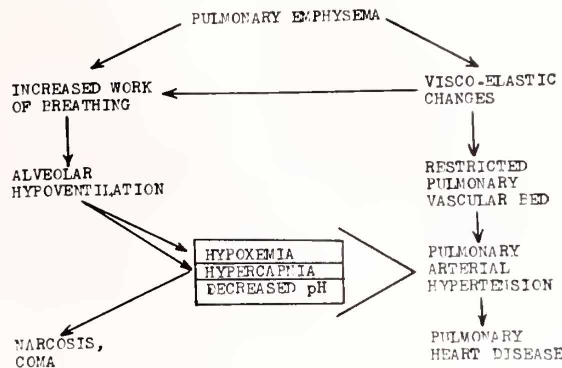

Fig. 2. Pathogenesis of alveolar hypoventilation and pulmonary heart disease in Chronic Obstructive Pulmonary Emphysema.

Cor Pulmonale

Pulmonary heart disease in pulmonary emphysema is caused by the increased cardiac work (right and left ventricles). The abnormally high pulmonary artery pressures and the normal pulmonary wedge pressure indicate that pulmonary arterial hypertension arises from increased resistance to blood flow in the pulmonary bed proximal to the left atrium.

The pulmonary arterial hypertension of pulmonary emphysema has diverse origins. The common denominator in all subjects appears to be compression and/or destruction of lung tissue which decrease the cross-sectional area of the vascular bed. Diminution in the distensibility, and distortion of vessels also are causative factors. Finally, to these anatomic changes may be added a functional increase in pulmonary vascular resistance imposed by arterial hypoxemia,[9] arterial hypercapnia[10] and increased arterial hydrogen ion concentration (decreased pH).[11] (Figure 2) The anatomic resistance would seem to be largely irreversible. On the other hand, functional resistances, such as hypoxemia, hypercapnia, decreased pH, polycythemia and hypervolemia are amenable to treatment. Indeed, the relief of these factors will not only lower the pulmonary arterial pressure and the work of the right ventricle, but also decreases the work of the left ventricle.

Summary

Although the term pulmonary emphysema is widely used in the clinical practice of medicine, its meaning varies in each specialty group.

Regardless of the underlying disease process, the physiologic changes in chronic obstructive pulmonary emphysema are the same: diffuse obstruction, primarily in the small airways and loss of pulmonary elasticity. As the disease progresses alveolar hypoventilation, pulmonary arterial hypertension and cardiac failure develops.

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Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

EDITORIALS

Appreciation To______
Our Readers and Advertisers

THE sum total of medical knowledge grows and grows, and out of this growth come the specialties and the subspecialties of medicine. The specialties seemingly begat more specialties and subspecialties and so on, ad infinitum. All these in turn have their own meetings, produce their own journals and communicate less and less with each other.

Thus it will become increasingly difficult for the medical profession to maintain some sort of unity. Yet some sort of unity is desirable, not just for political purposes alone, but as an effective force for the protection and the betterment of the public health.

In Kentucky the KSMA Journal is grateful that it serves as a tie that binds the medical profession of the state together. It is the medical home-town newspaper and a traveling bulletin board. Within its covers will be found the history of Kentucky medicine, ancient and contemporary. It serves an additional function, of course, as an instrument for continuing medical education.

There are a number of reasons to believe that a good many Kentucky doctors read at least parts of The Journal. For example, print something in it that is thought to be incorrect and the staff immediately hears about it!

The publication of the Journal is supported in part by membership dues and this is as it should be, but the Journal also receives valuable financial help from the outstanding companies and institutions that use its pages for advertising purposes.

We, on behalf of all the doctors in the state, take this opportunity at Christmas time to thank our advertisers for their support and for their demonstrated interest in cooperating with all of the activities of organized medicine. Christmas time is a good time to think about and to emphasize those ties that bind the doctors of Kentucky together rather than those differences that tend to divide.

WALTER S. COE, M.D.

Good Night and Good Morning

AS 1963 comes to a close it seems appropriate that we remember those of our colleagues who have died during the year. Their names are before me now—54 to date—many of them my own close personal friends. Mostly they were older physicians, but some were at the peak of their activity; some stood only on the threshold of the professional career for which they had spent gruelling and costly years in preparation.

These were men who had worked in crowded cities, in mining areas, in small towns and rural communities. They indeed represented every location and activity in our state. There were those who had achieved national renown in their respective fields; teachers whose students are spread over the world; missionaries who had taken healing to the dark corners of the earth; some had received awards of merit or distinction both civilian and military; some followed

the obscure and quiet path of service and brought relief and solace to God's humble multitude.

They lived and worked in a period of transition; their life was one of adaptation from the old and empiric art, to the new and more or less exact science, of medicine. They perhaps learned and discarded, relearned and replaced more medical knowledge than has any preceding generation. They had to be alert to keep up with the rapid progress of their time.

Mostly these men came into the profession because of its superior rating among vocations and its promise of high service to mankind. It was not required that they be exceptional scholars nor was there a course of training so exacting or prolonged as today. Their service was on a broader basis and their contacts more direct and personal. They learned much by trial and error, as in fact, we still do.

They performed professional and civic services to their communities which generally elevated them to the highest esteem among their fellows. Few acquired wealth, but they left a heritage of accomplishments for which they were honored and of which their families have just pride.

And one more thing—during the past 30 years they formed, with their colleagues of the nation, a strong opposition to repeated efforts at regimentation of medical practice. Education of the public and our profession concerning the threat to their welfare and to the individual freedom of physicians has thus far been reasonably successful in preventing, delaying or limiting socialization. It has taken vision, hard work, and persistence to resist federal control of medical care.

There is before me another list, 115 in all, of men who have come into the Association in 1963. There are mostly young men recently graduated and trained in their respective fields. To enter the profession in this day they are of necessity men of high scholarship. They were selected from a vast number of applicants because they were deemed superior men; furthermore, they proved their strength and stamina in that they survived the present rigorous period of school and hospital training. They are far better equipped at the onset of their career than were their predecessors.

Can they do as well for their age as have those who went before? We think they can and will. The spirit of medicine is inspiring and contagious. Each generation is stronger and better prepared than the last. It should be so, else we could make no progress.

To those who have gone, Good Night; may eternal tranquility and peace reward your productive lives. To those who come, Good Morning; may God help us all as we labor in the heat of the day to serve faithfully and well.

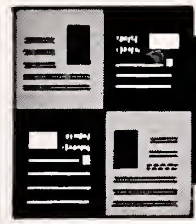
SAM A. OVERSTREET, M.D.

Logorrhea

IF THERE is one emotional reaction shared by all physicians—specialist or generalist, clinic or solo practice, salary or fee-for-service—it is an anxiety reaction about our inability to keep with the literature. A nodding acquaintance with the literature of other sciences shows that chemists, physicists, and biologists share this same problem. Reasonable estimates indicate that the production of scientific literature is doubling every decade. Even the literature on the new science of information retrieval is becoming cumbersome and irretrievable.

It has remained for an industralist to place this in perspective as a product of our environment. In a recent speech, Gerald L. Phillippe, President of General Electric, observed: "In the 18th century, the Declaration of Independence took 300 words; 100 years ago, the Emancipation Proclamation took 619 words; and a recent government order on the price of cabbage has 26,911 words".

GEORGE F. BROCKMAN, M.D.



SPECIAL ARTICLES

Solo Versus Symphony*

Clyde C. Sparks, M.D.
Ashland, Ky.

As a small boy in an eastern Kentucky rural community it did not occur to me that evil existed; that anyone would in any way take advantage of another; that anyone would steal, lie or cheat. As knowledge and experience extended beyond this small and limited community some rude awakenings occurred. I learned that all statements issued by people were not true and that people did on occasion lie, cheat and steal. It was discovered that selfishness was a reality.

From an awareness that evil existed, it was only a short step to amazement at the extent to which it could go. The most amazing thing was that an omnipotent God would permit such injustices, or tolerate some, or for that matter any, of the evil things I was beginning to see. I could as a child understand that people were different and had been created of unequal abilities, but it was inconceivable that wickedness could be so commonly present. The solution with its accompanying challenge came as maturity approached with the knowledge that men are given the right of choice by the divine creator. Man can be evil or good. He can be moral, immoral or amoral.

As far as I have been able to learn from history, God is the only autonomous personality permitting this freedom of choice and also the only one standing the test of time. In a Godless government the deprivation of the right of choice is not limited to religious freedom. Is it then unreasonable to ask if it would be an act of anti-deity to deprive people of a right to choose?

Times change. Principles do not. The right of choice exists in all component groups of our society. Nations, like individuals, can choose to rise or fall. Failure to change is damaging, but change at the expense of principle is deadly.

Perhaps here we should point out that our founding fathers saw clearly that certain freedoms were so basic that in order to guarantee their perpetuation, mentioned them as principles from which we should not depart. These have been impressed on us, and by generations of training have become an integral part of our American way of life. Our forefathers apparently did not foresee that we might be so naive, so careless, or so selfish as to permit changes which will, if carried much farther, destroy our ability to exercise our guaranteed rights.

If we in this country were told tomorrow that we could no longer choose our church, merchant, lawyer, dentist, or what-not, we would promptly rebel. Why, then, do we carelessly allow ourselves to be led into a situation where we will not be able to exercise our prerogratives of choice? Creeping socialism depends in America on this approach. The only escape from socialism is the state of Godless totalitarianism, which is worse. Again we must not allow ourselves to lose the ability to use our rights.

Not long ago I heard an acquaintance of mine, a pious gentleman, boast that he prayed daily that we would not depart from fundamentalism. He never did much about it, however. His life reminds me of the spinster who prayed daily that the saloon down the street would close. After months of unanswered prayers she solicited the help of her maid in this matter. A few days later the saloon burned to the ground. With great exultation she re-

*Presented at the April, 1963 Annual Meeting of the Kentucky Dental Association at Louisville.

ported the success of their prayers. The maid stoically answered: "Yassum, I puts action in my prayers." We cannot hope to survive by helping someone do nothing. Our social planners put action in their wishes. We might learn a lesson here.

In making decisions on change we often fail to observe that in some of the proposals there is enough emotional appeal or enough actual good to make them sound convincing and that at the same time there is enough concealed bad to spoil the entire barrel of apples. The masters of mass psychology seem never to overlook the first part of this, while we often overlook the second part. We also seem to forget that we as individuals have no corner on good, or that our neighbor is endowed with an immunity to temptation. I am sure all of us can recall experiences in which we saw others or ourselves begin to fulfill positions of trust with the highest ideals of service only to see these ideals decline in relative importance and become subservient to a program of expediency. This seems to be related in some way to the letter "I" making up one-third of the word sin.

History is full of incidents which teach the reward of adherence to basic principles and the consequences of their alteration. History likewise teaches us the role of individuals and of the group in maintaining the existence of or the destruction of these guiding codes of conduct.

Our society, complex as it has become, has not altered the role of the individual in the solution of community, national, or international affairs and, perhaps in the not-too-distant future, interplanetary affairs. The role of the leader must remain, in addition to personal influence, that of becoming a rallying point and, by becoming a follower, an integral part of the body politic. In the role of follower he must not become a nonentity, and as a leader, he must not become a dictator. It is an individual and collective responsibility to prevent this.

Perhaps we should recall lessons learned during the great movement westward in our own country by groups of people ill-equipped, save for dedication and determination, for such an undertaking. During such a movement the teacher learned manual labor, the blacksmith carried a rifle, and the minister stood his watch. If specialization had been carried to the fullest extent, as we seem to be doing now, our wagon trains would have never reached the Oregon Territory. The important thing was that a symphony was playing, but not at the expense of any one soloist.

I am not familiar with any recorded history which teaches that it is necessary to lose our individual integrity when we are a part of a program of living proven to be for the common good. It might be well to remember often that we are citizens first and medical and dental men second. Once again we find ourselves at a point where we can exercise the right to destroy our identity or maintain it, or we can be so careless and selfish as to allow the destruction of our individual and collective abilities to exercise the rights we have.

In such a complex society as ours, what can we as individuals do about preserving the things we hold so sacred, and how can we act collectively? The two must overlap, of course. We must, if we have not already done so, decide what we hold essential and basic. We must decide whether we need to protect or recapture. In either event we must begin at home. The individual is primarily the responsible party. Certainly preschool age is no barrier to the teaching of basic truths and how to resist the efforts of those who would have us deviate from them. Unfortunately these children may, in spite of our efforts, meet in school some influences in that direction.

The survival of our programs depends on how well we have done our job at home and how devoted we are, collectively, to the program of preservation or recovery, as the case may be. A fair percent of our difficulties can be traced to a lack of understanding. This is particularly applicable to such a melting pot of social and economic backgrounds that have made up America. This is in sharp contrast to some of our neighboring nations where the 'all-or-none' law of economic standards exists and where social progress must proceed at a snail's pace.

Most of us have noted that in our country, in spite of a relatively even distribution of material wealth and a relatively even level of educational attainment, more arrogance, envy, and resentment exists among and between component groups of our society than is compatible with a healthy society. It would then be a natural conclusion that certain essentials in our educational and social structure are either lacking or are in need of modification. In the first place, it is not very practical to give to any

group positions they are not emotionally or educationally ready to fill. Secondly, we are lagging almost to the point of failure in some cases in the teaching of vocational understanding or appreciation. We spend large sums in helping direct young people into vocations they are best fitted for, but how many children understand the role of the brick mason, the newspaperman, the merchant, etc., in the community? It is not hard to realize that apparent selfishness is at times merely lack of understanding. If some of these foundations are not laid during early years they will never be formed.

If, through proper training and education, along with understanding, we place these better-equipped youths in the body politic we should see less of a tendency and less susceptibility to the parasitic way of existence. It is our responsibility to these future citizens not to destroy the fearless and adventurous spirit of youth, and to shy away from anything that would foster an outlook of what I like to call "Fatal Futilism." In our communities we must make it easier and more desirable to work than to loaf, easier to be active rather than passive, and better to walk under your own power than to ride on the labors of others. Parasites and free-loaders should be done away with so far as possible.

It seems unnecessary to mention the efforts our social planners have made to change our way of life. I feel that change is needed, but if we review the long lists of legislative proposals, we find in some of them the loss of principle. For the most part they are directed at control, either intentionally or inevitably, as a consequence of their very nature. These are for the most part conducive to and dependent on an uninformed people for their existence. They are in general conducive to the manipulation of persons and they condone social revolution instead of a more rational and intelligent direction of proper social evolution. Currently the most dangerous plan is the King-Anderson proposal with its already familiar implications. Those who resent these unnecessary pieces of legislation must repeatedly win. In this type of conflict we can only lose once.

The great symphonic orchestral groups of our land are composed of large numbers of accomplished and talented musicians. Each one of these is capable of being a soloist, but the story they tell can only be told by harmonious group effort. They do not lose their identity in such a program of effort but contribute something that is of far greater value and which would otherwise be impossible. The shrinking size of our world may shift the focal point of government to national levels. It may possibly be shifted to international or even interplanetary levels. This would make our solo efforts less effective and require a symphonic effort to survive. It is my considered opinion that this will be of the utmost importance if we are not to follow other nations to unrest, dissention, and economic and moral bankruptcy.

We Wish You

A Very Pleasant Holiday Season

Sam A. Overstreet, M.D., Editor
and
The Journal Staff

The J. W. Holland Memorial Meeting of The Kentucky State Medical Association

Crystal Ballroom, Phoenix Hotel, Lexington, Kentucky, September 23-25, 1963

Digest* of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES*

Garnett J. Sweeney, M.D., Liberty

Speaker of the House, Presiding

First Session

Doctor Sweeney called the meeting to order and asked that Gabe A. Payne, Jr., M.D., of Hopkinsville, give the invocation. It was reported that a quorum was present by the chairman of the credentials committee, Harvey Chenault, M.D., Lexington. It was moved and seconded that the minutes of the 1962 meeting be accepted as published in The Journal. Motion carried.

General announcements were made by KSMA Secretary Woodford B. Troutman, M.D. Opening ceremonies were to begin at 8:45 Tuesday morning in the Crystal Ballroom of the Phoenix Hotel. Doctor Troutman stated that the hearings of the Reference Committees would begin Monday afternoon at 2:00 in the Phoenix Hotel. He announced that Reverend Dr. Henry M. Johnson of Fort Worth, Texas, would be delivering the address at the President's Luncheon and urged attendance.

At this time the list of physicians who had died since the 1962 meeting was read and the House stood for a moment of silence in their memory. The names of the physicians, their location and date of death are as follows:

Allen, Farris L., Ashland, February 16, 1963
Anderson, Donald W., Madisonville, May 4, 1963
Baker, Boyd V., Grayson, September 8, 1963
Baker, Melvin C., (Member), Louisville, January 3, 1963
Bledsoe, R. W., Covington, August 26, 1963
Bloch, Winston N., (Member), Louisville, January 26, 1963
Boyer, William F., Louisville, October 5, 1962
Collins, Robert Lee, (Member), Hazard, May 20, 1963
Davis, R. Hayes, (Emeritus), Louisville, March 27, 1963
Densford, Will L., Covington, January 18, 1963
Dick, Jack, Louisville, June 1, 1963
Dowden, Chauncey W., (Emeritus), Louisville, July 17, 1963
Eaton, William V. Jr., (Member), Paducah, June 9, 1963
Fish, Carlos A., (Member), Louisville, March 18, 1963
Francis, Charles M., Lexington, April 1963
Garred, Isadore M., (Member), Morehead, June 20, 1963
Gragg, Henry L., Junction City, April 8, 1963
Hancock, James C., Fulton, August, 1963
Harris, Orion W., (Member), Glasgow, October 13, 1962
Healey, Louise B., Lexington, October 23, 1962
Howard, William Proctor, (Member), Highsplint, June 29, 1963
Keeling, William H., (Member), Bloomfield, May 8, 1963
Kelly, Robert C., (Member), Louisville, September 5, 1963
Kemp, William C., Dixon, March 4, 1963
Lane, Joe E., (Member), Lexington, September 29, 1962
Liebert, Louella H., Louisville, May 5, 1963
Lowrey, George E., Harrodsburg, February 19, 1963
Lukins, Lanier, (Member), Louisville, September 19, 1963
McCarty, A. Clayton, (Member), Louisville, August 1, 1963
Malagrino, Philip J., Louisville, February 14, 1963
Martin, Edward K., (Member), Frankfort, December 1, 1962
Miller, Arcy O., (Member), Scottsville, July, 1963
Miller, Orville R., Fern Creek, March 30, 1963
Nestley, Edward J., Covington, July, 1963
Nichols, Luther E., Princeton, March 28, 1963
Odom, Stanley G., (Emeritus), Covington, October 13, 1962
Otey, Ira G., Melber, January, 1963
Osborne, Paul S., (Member), Louisville, November 6, 1962
Ozment, William Lee, (Member), Leitchfield, October 29, 1962
Palmore, E. E., Horse Cave, July 9, 1963
Pirkey, E. L., Louisville, July 29, 1963
Puess, Eugene F., London, August 16, 1963
Radcliffe, T. M., Smithland, September 30, 1962
Ripy, Howard, Lexington, September 3, 1963
Robertson, George A., (Emeritus), Louisville, June 13, 1963
Runyon, E. T., (Emeritus), Ewing, June 18, 1963
Smith, E. Dargan, (Emeritus), Owensboro, August 17, 1963

**Editorial Note: A complete tape recording was made of the two sessions of the House of Delegates, and any member who desires to examine the complete transcript of the proceedings, may come to the headquarters office and listen to the recording.*

Stambaugh, H. G., Ashland, October 9, 1962
Standard, John E., (Emeritus), Elkton, May 12, 1963
Suitt, R. Burke, (Member), Harlan, October 20, 1962
Thompson, William R. Jr., (Member), Lexington, August 16, 1963
Thorsness, Edwin T., Pikeville, April 25, 1963
Threlkel, Frank H., (Member), Owensboro, October 1, 1962
Usher, H. V., (Emeritus), Mayfield, October 31, 1962
Webb, Robert G., Livingston, November 23, 1962
Weiss, Morris M., Louisville, February 25, 1963
White, George W., (Emeritus), Henderson, April 14, 1963
Willmoth, Argus D., (Emeritus), Louisville, July 1, 1963
Wilson, Edward S. Sr., Pineville, March 21, 1963
Witt, Notley C., (Emeritus), Franklin, December 12, 1962
Woodbridge, C. L., Middlesboro, August 2, 1963
York, James W., Canmer, November 14, 1962

The Speaker announced the reference committee appointments, subject to the approval of the House of Delegates, as follows:

Reference Committee No. 1—Reports of Officers and Board of Trustees

Ballard W. Cassady, M.D., Pikeville, Chairman
Walter R. Byrne, M.D., Russellville
Guy C. Cunningham, M.D., Ashland
Paul J. Ross, M.D., Louisville
George H. Widener, Jr., M.D., Paducah

Reference Committee No. 2—Scientific Assembly and Medical Education

Kenneth J. Eblen, M.D., Henderson, Chairman
Guinn S. Cost, M.D., Hopkinsville
Ralph M. Denham, M.D., Louisville
Paul H. Klingenberg, M.D., Covington
John M. Reed, M.D., Mayfield

Reference Committee No. 3—Legislative Activities

E. C. Seeley, M.D., London, Chairman
James W. Miller, M.D., Greensburg
Bernard J. Schoo, M.D., Louisville
Frederick R. Scroggin, M.D., Dry Ridge
James G. Sills, M.D., Hardinsburg

Reference Committee No. 4—Public Service and Allied Professions

Paul J. Parks, M.D., Bowling Green, Chairman
Richard A. Allnutt, M.D., Covington
James W. Archer, M.D., Paintsville
N. L. Bosworth, M.D., Lexington
Paul E. Lett, M.D., Lancaster

Reference Committee No. 5—Medical Service

Russell L. Hall, M.D., Prestonsburg, Chairman
William W. Hall, M.D., Owensboro
Andrew M. Moore, M.D., Lexington
Lewis E. Wesley, M.D., Liberty
Robert L. McClendon, M.D., Louisville

Reference Committee No. 6—Constitution and Bylaws; Special Committees

M. Randolph Gilliam, M.D., Lexington, Chairman
John D. Allen, Jr., M.D., Louisville
Harry J. Cowherd, M.D., Frankfort
Richard E. Davis, M.D., Central City
J. Sankey Williams, M.D., Nicholasville

Reference Committee No. 7—Miscellaneous

Hollis Johnson, M.D., Louisville, Chairman
Harold B. Barton, M.D., Corbin
L. F. Beasley, M.D., Franklin
Norma T. Shepherd, M.D., Hopkinsville
Joseph H. Saunders, M.D., Lexington

Motion was made and seconded that the reference committee appointments be accepted as made by the Speaker. Motion carried.

The reports of the officers and committees were presented at this time and referred to the respective reference committees by the Speaker as follows:

Report of the President—Reference Committee No. 1

Report of the President (Page 1, Paragraph 6)—Reference Committee No. 5.

Report of the President (Page 2, Paragraphs 2 and 3)—Reference Committee No. 4

Report of the Woman's Auxiliary—Reference Committee No. 1

Report of the President-Elect—Reference Committee No. 1

Report of Speaker of House—Reference Committee No. 1

Report of Chairman, Board of Trustees—Reference Committee No. 1

Special Report on Finances from the Board of Trustees—Reference Committee No. 6

Special Recommendation from the Board of Trustees on Physicians Registration—Reference Committee No. 5

Doctor Sweeney then announced the appointment of the following physicians as tellers: Richard J. Wever, M.D., Paris, Chairman; Wyatt Norvell, M.D., New Castle; and Herman R. Moore, Jr., M.D., Louisville

William H. Bizot, M.D., chairman of the Awards Committee, presented the committee's nominations as follows:

Distinguished Service Medal—Sam A. Overstreet, M.D., Louisville

A motion was made and seconded and carried that Doctor Overstreet be the recipient of the Distinguished Service Medal.

Outstanding General Practitioner Award—Adam G. Osborne, M.D., Pikeville.

A motion was made, seconded, and carried that Doctor Osborne be the recipient of the Outstanding General Practitioner Award.

Other reports were received and referred as follows:

Report of the Secretary—Reference Committee No. 1

Report of the Secretary (Page 6, Paragraph 2)—Reference Committee No. 6

Report of the Editor—Reference Committee No. 1

Report of the Treasurer—Reference Committee No. 1

Report of the Delegates to AMA—Reference Committee No. 1

Report of the Executive Secretary—Reference Committee No. 1

Council on Scientific Assembly—Reference Committee No. 2

Council on Medical Education and Hospitals—Reference Committee No. 2

Council on Legislative Activities, Parts I and II—Reference Committee No. 3

Report of KSMA Representative to National Legislative Conference—Reference Committee No. 3

Council on Medical Services—Reference Committee No. 5

Council on Communications and Public Service—Reference Committee No. 4

Council on Allied Professions and Related Groups—Reference Committee No. 4

Report of the Advisory Committee to the Editor—

Reference Committee No. 6

Report of the Professional Relations Committee—Reference Committee No. 6

Report of the Committee on Third Party Medicine—Reference Committee No. 6

Report of the Committee to Study the Constitution and Bylaws—Reference Committee No. 6

Report of the Interim Meeting Committee—Reference Committee No. 6

KSMA Representative to Conference of Presidents and Other Officers of State Medical Associations—Reference Committee No. 7

KSMA Representative, U. of K. Chapter, Student AMA—Reference Committee No. 7

KSMA Representative, U. of L. Chapter, Student AMA—Reference Committee No. 7

KSMA Representative on Kentucky Poison Control Program—Reference Committee No. 6

KSMA Representative on State TB Coordinating Council—Reference Committee No. 4

McDowell Home Committee—Reference Committee No. 7

Building Committee—Reference Committee No. 7

Board of Directors, Kentucky Physicians Mutual, Inc.—Reference Committee No. 5

Board of Trustees, Rural Kentucky Medical Scholarship Fund—Reference Committee No. 5

Advisory Committee to Selective Service—Reference Committee No. 5

KSMA Representative, Advisory Committee on Maternal and Child Health, State Department of Health—Reference Committee No. 7

KSMA Representative on Kentucky Health Council—Reference Committee No. 4

Memorials Commission—Reference Committee No. 7

Technical Advisory Committee on Indigent Medical Care—Reference Committee No. 5

New Business

The new business was then presented to the House and referred to reference committees by the Speaker as follows:

(A) Resolution of Campbell-Kenton County Medical Society concerning Ratio of AMA Offices Held by Members in Private Practice and Medical School Faculties—Reference Committee No. 2

(B) Resolution of Campbell-Kenton County Medical Society on the subject of Participation in Third Party Plans—Reference Committee No. 5.

(C) Resolution of Campbell-Kenton County Medical Society concerning Interns Serving in Private Hospitals—Reference Committee No. 2.

(D) Resolution of Campbell-Kenton County Medical Society on the subject of Indoctrination of New Members—Reference Committee No. 4.

(E) Resolution of Campbell-Kenton County Medical Society concerning Holding House of Delegates in Executive Session—Reference Committee No. 6.

(F) Resolution of Campbell-Kenton County Medical Society on the subject of Clarification of Service Covered by Blue Cross and Blue Shield Plans—Reference Committee No. 5.

(G) Resolution of Campbell-Kenton County Medical Society concerning Limiting the Use of X-Ray Machines—Reference Committee No. 3.

(H) Resolution of Harlan County Medical Society on the subject of Commending the Woman's Auxiliary to KSMA—Reference Committee No. 1.

(I) Resolution of Bell County Medical Society concerning Physician Offices in Hospitals—Reference Committee No. 2.

(J) Resolution of Jefferson County Medical Society on the subject of Kentucky Penal and Parole Systems Report—Reference Committee No. 5.

(K) Resolution of Campbell-Kenton County Medical Society concerning Alternate Trustees—Reference Committee No. 6.

(L) Resolution of Muhlenberg County Medical Society regarding Board of Trustees Recommendations on Medical Care—Reference Committee No. 5.

(M) Resolution of Laurel County Medical Society on the subject of Implementation of Resolution 68 passed by the American Medical Association's House of Delegates, June 19, 1963—Reference Committee No. 2.

The meeting places for the Nominating Committee for general officers and the six Trustee Districts were announced by the Speaker. He stated that the Nominating Committee would report immediately at the close of the first scientific session on Tuesday morning in the Crystal Ballroom, and that on Wednesday night at the second meeting of the House, these nominations would again be read, and, according to the Bylaws, additional nominations could be made from the floor without discussion or comment.

With there being no further business, the meeting adjourned at 11:35 a.m.

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Second Session

The second session of the House of Delegates was called to order on September 25, 1963, by the Speaker Garnett J. Sweeney, M.D., and N. L. Bosworth, M.D., was asked to give the invocation. Harvey Chenault, M.D., reported that a quorum was present.

The Chairman of the Board of Trustees, Keith P. Smith, M.D., presented the final report of the Board as follows:

"The Board submits the following resolution, passed at its September 25 meeting:

"WHEREAS, the 1963 Annual Meeting of the Kentucky State Medical Association has been well attended and generally accepted as being one of the outstanding meetings that this Association has held, and

"WHEREAS, the Council on Scientific Assembly, our guest speakers, fourteen cooperating Specialty Groups and all others worked together so successfully in developing an outstanding scientific program, and

"WHEREAS, the University of Kentucky has developed and presented a most profitable Color TV program of four and one-half hours in length, and

"WHEREAS, the Smith, Kline and French Laboratories, at considerable expense, used their Color TV broadcasting facilities to greatly enhance the effectiveness of our meeting, and

"WHEREAS, the staff of the Phoenix Hotel, along with many other organizations and individuals, have cooperated to help make this meeting successful,

"NOW THEREFORE, BE IT RESOLVED that the House of Delegates of the Kentucky

State Medical Association go on record as expressing its deep appreciation to all individuals and organizations that had any part in developing and presenting the 1963 Annual Meeting."

It was moved and seconded to accept this resolution. Motion carried.

Doctor Troutman gave the announcements and urged everyone to attend the KEMPAC Seminar that would be held on Thursday, September 26, at the Lafayette Hotel, at the close of the afternoon scientific session.

The Speaker of the House then introduced Charles L. Goodhand, M.D., of Parkersburg, West Virginia, the President of the West Virginia State Medical Association, and James M. Moss, M.D., of Alexandria, Virginia, the first Vice-President of the Medical Society of Virginia.

The reports of the Reference Committees were then presented.

REFERENCE COMMITTEE NO. 1

Ballard W. Cassady, M.D., Chairman
Report of Officers and Board of Trustees

Report of the President

Most doctors take Thursday afternoon off, so the executive staff has arranged most committee meetings on that day; therefore, it was my good fortune to be privileged to attend most of the meetings. I would like to thank all committee members for their attendance and work. They have done a marvelous job with conditions that were sometimes very difficult.

I attended seven trustee district meetings. It was a real pleasure to visit so many fine doctors and to discuss with them some of our mutual problems. This has afforded me the opportunity of seeing more of our beautiful state.

In attending four surrounding states' annual meetings and in comparing their activities with those of Kentucky, I have become very proud of our doctors, the KSMA and its numerous activities.

There have been a few instances requiring grievance committee activity. Counseling with these men has been beneficial to the individual, the public, and to the profession.

A cult problem has been studied, together with several professional allied groups and definite plans are being laid to help protect the citizens from being over sold by irresponsible members of our society; and I don't mean Medical Society.

The AMA Board of Trustees members are limited to three three-year terms. The KSMA Trustee members are limited to two three-year terms. I would like to suggest that this House of Delegates recommend through our Advisory Commission to Blue Shield that the Kentucky Physicians' Mutual change their Bylaws to conform to the same general principle as the AMA. Furthermore, I would recommend that this program be implemented in the same manner as was employed in the changing of the system limiting the number of terms that can be served on the State Board of Health. In the case of the members of Kentucky Physicians' Mutual Board of Directors, it would mean that present directors if re-elected, would be allowed to serve three terms after the new rule became operative. This change would relieve present Directors with long service records, of any sense of obligation to remain on the Board, and would give other able physicians an opportunity to be of service to Blue Shield and its thousands of policy holders. I have attended several Blue Shield Board meetings and I believe that each and every member is dedicated and each is doing magnificent work.

Annual registration of physicians in the state should be considered so that we will know when a new man comes into the state or leaves either permanently or to take advanced training. One of the most used services of KSMA is providing information on the physicians in the state. Often the Association is embarrassed because under the present hit or miss system, it is not possible to maintain accurate records.

The KSMA Council on Communications and Public Service was asked by the 1962 House of Delegates to make recommendations to the 1963 session of the House on a system of mandatory indoctrination of new KSMA members. (The 1962 House did not feel a voluntary plan was adequate.) Gentlemen, if you were to serve as an officer in this organization and you really wanted to see it fulfill its true potential for service to the public and the profession, you would certainly concur in the need for more and more young men to become knowledgeable and proficient in the operation of the association's program and policies. In order to supply this need, the Council will recommend what I believe to be a carefully planned and very practical mandatory indoctrination program. Medical organizations we belong to require us to meet certain standards. We sincerely hope that you will support in the interest of building a more useful profession, the Council's recommendation.

The KSMA Committee on Hospitals has spent several days and attended many meetings during the past year in attempting to be of service to our people in the transfer of the UMWA Hospitals to the Appalachian Council. I would urge that we continue to study the problem and give continuing strong support to maintaining the fee for service and free choice principle.

The new KSMA Headquarters Building has added much to the efficiency of our organization. There is an ever-increasing number of duties, activities and opportunities for service. This requires more member activity, more staff effort, and an increase of time and resources if we are to adequately fill the need in assuming the responsibility of protecting the health of the people of Kentucky.

Ladies and gentlemen of this House, I thank you for this opportunity to make these recommendations for your consideration.

David M. Cox, M.D., Louisville
KSMA President

Recommendations, Reference Committee No. 1

Reference Committee Number 1 recommends acceptance of that portion of this report not referred to other committees and we wish to compliment the President for the excellent job which he has done during his term in office.

Mr. Speaker, I move the acceptance of this section of the report. (The motion was seconded and carried.)

Report of the Woman's Auxiliary

The sun shines bright on *my* Old Kentucky Home —the reflected radiance of 1360 Auxiliary members excellence in achievement.

While other states of the union cope with problems of population explosion our Commonwealth Auxiliaries cope with a rural population loss and it is disheartening to report that each year Kentucky loses one or more of its rural organized Auxiliaries.

Only because of heroic work by Mrs. J. Murray

Kinsman, President Elect, and her state membership committee of Councilors, Vice Presidents and Co-Ordinator of Members at Large, and Fayette County's 34.7% population gain with a resultant 17% Auxiliary membership gain, is it possible again this year to top the 1962 overall membership.

But the ingenuity and imagination used by one rural area Auxiliary to meet its problem deserves special acknowledgement. Their answer is Associate memberships. Muhlenberg County, with 9 physicians (wives all enrolled) came up with a total membership of 32 by extending Associate membership to physician's widows, daughters, sisters and mothers. While such numerical claim to kinfolk is not remarkable in Kentucky—remarkable is the spark of foresight to recognize the service potential of 32 members against 9 members; enabling their Auxiliary to raise funds for their local hospital and for AMERF, and to participate in an ambitious and far-reaching legislative program. Within this same group individual Auxiliary members serve as Chairmen of the Health committees of the Local Woman's Club, the PTA and as teachers of the American Red Cross Lifesaving & Water Safety and the Home Nursing classes. This county's aim for excellence in achievement scores a bull's-eye.

Kentucky's particular emphasis this year has been to fit the National Auxiliary programs to the needs of the individual Kentucky communities, and while all twenty-three Auxiliaries have worked diligently on Legislation, there has been accordingly greater or lesser involvement with AMAERF, CD, Safety, Rural Health, Mental Health and International Health. Community Service has been broadly based and the deed has fit the need.

The State Health Careers loan fund, in its 13th year, is currently assisting three students studying for BS degrees in Nursing (one an honors student); seven county Auxiliaries sponsor Allied Medical Careers loan funds and two county Auxiliaries offer Allied Medical Careers scholarships. Four counties sponsored career days and several counties sponsor Candy Stripers; one Auxiliary conducts training for hospital orderlies and nurses' aides.

Community Service has embraced health education and volunteer health service in all the usual disease and health fund drives as well as state-wide Sabin Oral Vaccine innoculations in which three counties included blood typing, hemoglobins and RH factors. One county did Glaucoma screening of residents and one county staffed Typhoid innoculation clinics in the Kentucky flood area.

Other activities include volunteers service in Hospital Auxiliaries, 8 counties; Tuberculosis, 12 counties; Cancer, 5 counties; Heart, 10 counties; Penal & Correctional institutions (service and/or funds) 3 counties; Mental Health activities in 9 counties; Handicapped children, 7 counties; Underprivileged children's camps, 1 county; Orphan's homes, 1 county; PTA, 23 counties including the health services of first aid rooms, dental & medical pre-school check-ups and physical fitness programs.

At the request of the American Cancer Society one Auxiliary is participating in a six year research program for 300 persons.

All 23 Auxiliaries promoted legislative education on medical issues besides member participation in precinct work, campaigns to Get Out the Vote and various League of Women Voters projects.

Three Kentucky Auxiliary members have accompanied their husbands on "working vacations" to practice medicine in International Health type projects in Haiti, British Honduras and the Belgian Congo. One Auxiliary member was cited by receiving the University of Kentucky's highest honor, *The Sullivan Medallion,* for her weekly Open House to foreign students which she and her physician husband have held weekly since 1956.

Another example of fitting the deed to the need is Franklin County Auxiliary's sponsorship of three Cuban refugee medical families taking temporary residence in the United States, the doctors practicing medicine with the Kentucky State Board of Health. Auxiliary engages a language teacher for English instruction of the ten Cubans and Auxiliary members offer sympathetic counsel and guidance to help smooth the countless bewildering aspects of life in a strange land. Temporary financial assistance was supplied, also, during the first 90 days of the Cubans' residence—the necessary time required by Commonwealth law to process a first paycheck.

Another Health Citation Award will be made this year to a layman for outstanding work in the field of health and welfare. This award, inaugurated in 1955, recognizes and encourages work by laymen in health fields. Recipients have been both men and women and candidates are nominated by county Auxiliaries with the award being made at the annual meeting.

I record Kentucky Auxiliary members' achievements with pride. Our aim was for excellence in achievement and if our service range has been broader or narrower than National recommendations it was tailored to fit Kentucky's various needs at a community level.

Mrs. James Sears Rich, Lexington, President
Woman's Auxiliary to KSMA

Recommendations, Reference Committee No. 1

Reference Committee Number 1 recommends the acceptance of this report and wishes to commend the President and her fellow members for an excellent job well done.

Mr. Speaker, I move the acceptance of this section of the report. (Motion was seconded and carried.)

Report of the President-Elect

This has been a very interesting and profitable year for me as your president-elect as I have served my apprenticeship for the high office with which you have honored me for the coming associational year.

Routine assignments have included serving on the Council on Scientific Assembly, which group, of course, is responsible for developing and presenting this annual meeting. We believe that you will find it to be one of the best you have attended.

I represented your president at the Ohio State Medical Association Annual Meeting, attended both meetings of the AMA House of Delegates, and went to the very profitable AMA Institute held in Chicago last month. These meetings provide you with the depth and scope of the problems that medicine is facing and constitute a significant adjunct to the process of indoctrination. If we might express the personal view we wish every delegate might have had the opportunities during the past year that I have had to become acquainted with medicine's problems.

In addition, I have participated in various ways in the Association's interest with respect to developments having to do with the transfer of UMWA Hospitals to the Appalachian Regional Hospitals, Inc., and have been involved in trying to solve some of the problems incident thereto.

In addition, we attended the annual Interim Meeting in Covington this year, which was an unusually good meeting and which set an attendance record.

I have filled several speaking engagements by virtue of my office as president-elect.

One of the most encouraging things to me has been the growth of the realization on the part of the Association's Board of Trustees, House of Delegates, councils, and committees of the consciousness of their responsibility and the role that medicine as an organization should play in seeking to render a more useful service both to the profession and the people we serve.

With the opportunities that you have given me as a member of the Council on Legislative Activities, as alternate delegate, delegate and president-elect

there have naturally come to our attention a number of areas of acute and pressing needs in which we as an association should be able to make an important contribution. We will expect to enumerate a few of these Wednesday evening at the second meeting of the House of Delegates.

Again, I would like to thank you for the confidence that you have placed in me.

George P. Archer, M.D., Prestonsburg
President-Elect

Recommendations, Reference Committee No. 1

Reference Committee Number 1 recommends the acceptance of this report and commends the President-Elect for his action during the past year and pledge our whole-hearted support (along with all members of the KSMA) during the coming year.

Mr. Speaker, I move the acceptance of this section of the report. (Motion was seconded and carried.)

Report of the Speaker

Inasmuch as this is my first meeting of your House of Delegates as speaker, there is little of interest that I can report to you other than participation in routine preparations for the two meetings of this House.

We would like to point out that we are experimenting with one innovation, which is designed for the convenience of the members of the House and others who wish to attend reference committees this afternoon and testify on specific matters under consideration.

There will be in each reference committee room a blackboard on which will be listed all of the items that will be considered by the reference committee in the order in which they are to be taken up. After testimony is completed on each item a line will be drawn through it but not erased. In this manner those attending the committees will be able to judge approximately when to be present for a given item. If the item has already been handled, the individual will then be able to submit a statement in writing to the committees, which may be considered in executive session.

Your speaker and vice-speaker along with the officers and members of the Board of Trustees urge you to attend the reference committee meetings, which will start at 2:00 p.m., this afternoon on the third and fourth floors of this building and give the reference committee members the benefit of your views.

Garnett J. Sweeney, M.D., Liberty
Speaker of the House

Recommendations, Reference Committee No. 1

Reference Committee Number 1 recommends acceptance of this report of the Speaker of the House and commends him for his activities.

Mr. Speaker, I move the acceptance of this section of the report. (Motion was seconded and carried.)

Report of the Chairman of the Board of Trustees

Many significant matters were considered by your KSMA Board of Trustees at the six meetings it had including the one on August 8. Among the highlights were actions taken to establish an Insurance Review Board, clarify the association's position on matters of free choice of physician, fee for service, and offices in hospitals in the East Kentucky developments, and act on legislative and budgetary matters.

The following pages do not purport to give all of the action and discussion that was taken in these six meetings. We will, however, report the more important decisions. Any member may present himself at the headquarters office and request an opportunity to read the Board's minutes.

Prior to the September 20 meeting of the Board, 147 physicians spent 834 man hours and traveled 29,678 miles in carrying on the business of the association. The Executive Committee of your Board had three meetings at which there were 28 physicians present, 140 man hours spent, and 4,000 miles traveled.

We are sure that you will agree that these figures demonstrate the seriousness with which members of the Board undertake to discharge their responsibilities. You are also aware that the only compensation these men derive from these sacrifices is the knowledge that they have done their best to serve their colleagues and the people of Kentucky. It is not an uncommon thing for the Board to remain in session for eight consecutive hours.

First Meeting—The reorganizational meeting of the Board of Trustees was held September 20 with Woodford B. Troutman, M.D., serving as temporary chairman. First order of the business was the election of the Chairman of the Board for the new year. Keith P. Smith, M.D., Corbin, was chosen for this office.

Newcomers to the Board were then recognized. They were: George P. Archer, M.D., Prestonsburg, president-elect; Alfred O. Miller, M.D., Louisville; Hugh Mahaffey, M.D., Richmond; and Joseph R. Miller, M.D., Benton, vice presidents; Gabe A. Payne, M.D., new trustee from the Third District and O. Leon Higdon, M.D., new trustee from the First District. Garnett Sweeney, M.D., newly elected speaker of the House and George F. Brockman, M.D., vice-speaker along with trustees, Thomas Meredith, M.D., Dixie Snider, M.D. and William Hambley, M.D., who returned to the Board for a second term.

The Board then proceeded with the election of the remainder of its officers and the formation of its Executive Committee. John Pepper Glenn, M.D., Russellville, was chosen vice-chairman and Hubert Jones, M.D., Berea, and Carlisle Morse, M.D., Louisville, were elected to serve with the President, President-Elect, Chairman, Vice-Chairman and Secretary to form the Executive Committee.

The Board then proceeded to elect the personnel for the KSMA councils, committees, and standing committees that had been nominated by the Executive Committee, which sits as a nominating committee for this special purpose earlier.

Recommendations of the President were then heard. The Board proceeded to consider the actions of the House of Delegates relative to holding the 1963 Annual Meeting in Lexington. A committee was appointed to see if appropriate arrangements could be made.

Doctor Norvell presented his resignation as trustee for the Seventh District having been chosen delegate to the AMA, replacing Doctor Archer. Following provisions of the Bylaws, the trustees then moved to obtain nominations from the delegates in the counties of the Seventh Trustee District relative to a replacement.

Second Meeting—The President reported that the Council on Scientific Assembly and the Scientific Program Committee had met for the purpose of getting plans for the 1963 Annual Meeting underway and that the Specialty Group Presidents were scheduled to meet later in December on the 1963 Annual Session to be held in Lexington.

He reported that an excellent program had been arranged for the March 7 Interim Meeting in Covington.

The senior delegate from the KSMA to the AMA made his report on the Interim Meeting of the AMA House of Delegates to the Board of Trustees and stressed the highlights of the meeting.

Following this report, the President stated that due to the retirement of Hugh Hussey, M.D., Washington, D. C., as a member of the Board of Trustees of the AMA, a vacancy had been created on the AMA Board of Trustees. He stated that our senior delegate, Doctor Long, had been encouraged to make the race for this position. Following a brief discussion, the Board of Trustees unanimously agreed to support Doctor Long when the election is held at the Annual Meeting of the AMA in June 1963 at Atlantic City.

The recommendation of the Council on Medical Education and Hospitals relative to the reorganized office of continuing medical education was heard. The recommendation was that a new secretary-stenographer be employed with the continuing medical education office paying one-third of her salary and that she was to keep the master schedule of all postgraduate meetings held in Kentucky and that the material for the postgraduate page in The Journal of KSMA would be kept by her, that she was to work under the supervision of Robert G. Cox, who would serve as secretary to the Committee. The recommendation passed.

The President stated that the Kentucky Urological Society had petitioned the Board to become one of the cooperating specialty group societies participating in our Annual Meeting. The recommendation was unanimously accepted.

The Board accepted the recommendation of the Council on Scientific Assembly relating to awards. This recommendation was that the award given for the best scientific exhibit and the two awards for programs carried out by the faculty members of the two universities for outstanding service would be given, not necessarily every year, at an appropriate time during the scientific assembly instead of at the President's Luncheon. The recommendation passed.

Due to reapportionment of Kentucky Congressional Districts and since there are only seven, it was necessary to reorganize the KSMA Legislative District Key Man System. The nominations of the Council on Legislative Activities for these seven positions were presented and the Key Men were appointed.

The Trustees accepted the recommndation of the Council on Legislative Activities that KEMPAC (Kentucky Educational Medical Political Action Committee) as the political arm of the medical profession should be the agency to interview the candidates for governor.

The recommendation of the Executive Committee to the Board of Trustees relative to holding meetings in all of the trustees districts on political action was considered and accepted. The House of Delegates' mandate to the Council on Legislative Activities to develop and present a program of general education for the public on operation of cults in Kentucky was considered and a progress report of the Council was made.

The mandate of the House of Delegates for the Board of Trustees to study the matter of reapportionment of the trustee district system in Kentucky was referred to the KSMA Bylaws Committee.

After reports by the various trustee district grievance committees, the President called attention to the efforts of the association to get its members to affiliate with the Kentucky Chamber of Commerce. The recommendations of the Membership and Placement Committee were presented by its Chairman Claude E. Cummins, Jr., M.D., Maysville, in a full report explaining the inadequacies of our present system of keeping records of physicians in Kentucky and he stated that after careful consideration and consultation with the secretary of the State Board of Health that his committee was recommending an annual registration of all Kentucky physicians and pointed out that this could be done without charging a fee or passing a law.

After discussion, it was voted that there be a recommendation to the House of Delegates from the Board of Trustees that this plan be approved.

It was then pointed out that Wyatt Norvell, M.D., trustee from the Seventh District, upon being elected as a delegate from KSMA to the AMA had resigned as trustee pending the appointment of a replacement. President Cox stated that as provided by the Bylaws the Seventh District had been polled by him and that Donald Chatham, M.D., Shelbyville, had received a substantial majority of the nominations. Following discussion, Doctor Chatham was elected to serve as trustee from the Seventh District until the next regular meeting of the House of Delegates.

There was a discussion of the meeting called by the Governor at Harlan, Kentucky, on January 10 to discuss what should be done about the four UMWA Hospitals that the Union is planning to close June 1. Inasmuch as the association had been asked to send representatives, it was felt that these representatives should be given some instruction. Following discussion, the Board authorized its representatives to make sure certain basic principles in the operation of hospitals and their relationship with the community and the union could be stressed.

It was decided that the date of the next meeting of the Board would be Wednesday, March 6, at 4:00 p.m., at the Town and Country Restaurant at Covington just prior to the 1963 Interim Meeting on March 7 at the same location.

Third Meeting—Following a report of the President which showed an intense amount of activity since the December 13 meeting of the Board and a report of the Headquarters Office, the Board replaced vacancies that existed on certain KSMA committees.

It voted to officially express to the American College of Obstetrics and Gynecology its appreciation for a $250 gift to the McDowell Home.

It was explained that two of the terms of appointees on the State Board of Health from the KSMA expired on December 31, 1962, and due to an oversight were not considered at the December 13 meeting of the Board. It was pointed out that the terms of E. M. Howard, M.D., chairman of the Board, and Fred Moberly, M.D., Lexington, had expired.

The Board refused to accept a recommendation that it rescind a policy established some eight years ago by the Board (then known as the Council) that the association would not nominate the same man for a position on the Board for more than two consecutive terms. It was pointed out that this policy was again considered in 1960 and was interpreted to mean that it would not be put into effect until all members of the Board nominated by KSMA might have an opportunity to serve two more terms after appointment by the Governor.

It was explained that for each M.D. opening on the Board of Health the law provided that KSMA should nominate three physicians from which the Governor would appoint one. The Board then proceeded to nominate for the position now held by Doctor Howard: George P. Archer, M.D., Prestonsburg, C. Dana Snyder, M.D., Hazard, and Clyde C. Sparks, M.D., Ashland; for the position now held by Doctor Moberly: Sam A. Overstreet, M.D., Louisville, David M. Cox, M.D., Louisville, and Daniel Costigan, M.D., Louisville.

The Board then considered certain recommendations from the KSMA Councils. From the KSMA Advisory Commission through the Council on Medical Services, the following recommendations were presented:

1. That the Kentucky Blue Shield Plan report to the House of Delegates on the progress of the Senior Citizens Program for the calendar year each year, rather than from April to April as was suggested at a special meeting of the House of Delegates in 1962. It was taken by consent that this be done.

2. The next recommendation from the Blue Shield Advisory Commission related to the composition of

the Board of Directors of Kentucky Physicians Mutual, which is the Blue Shield Plan for Kentucky, that it be recommended to the proper authorities that a reasonable balance of representation of the various physician specialties be placed on the Board of Directors of Kentucky Physicians Mutual. This motion carried.

3. After hearing a recommendation from the Advisory Commission relative to the establishment of the Insurance Review Board, there was considerable discussion among the members. It was stated that the purpose of the proposed board would be not only to help adjudicate alleged abuses on the part of physicians working for third parties, but would give physicians who felt aggrieved by third parties a voice in the recommendations made to third parties. After discussion, the Board approved the idea in principle and authorized the Commission to bring in a specific proposal for the next meeting of the Board.

4. The final recommendation of the Advisory Commission related to a special proposed four-page Blue Shield insert into The Journal of KSMA. Such matters as implementing the Senior Citizens Program, adjudicating claims, and other related problems would be handled. Cost of the insert would be born by the Blue Shield. It was also indicated that the Health Insurance Council would be given the same opportunity to have this four-page insert if desired. The Board approved the recommendation.

Another recommendation from the Council on Medical Service came from the Mental Health Committee. It was requested that the AMA program for mental health be approved, that it be brought to the attention of the KSMA membership, and that our own association enter into a long-range planning program for Kentucky. After brief discussion, the recommendation was approved.

A recommendation from the Council on Communications and Public Service relating to participation in a research program on fatal highway collisions was made and approved.

The Board voted to send the Chairman of the KSMA Committee on Aging to the Third National Conference to Improve Health Care of the Aged in San Francisco, May 2-4.

A report from the Chief of the Audit Division of the Louisville office of the Internal Revenue Bureau stated that KSMA members paying their own way to the Congressional Dinner in Washington could not deduct the expense from their income tax.

The Board then heard reports of the various Trustee District Grievance Committees and acted on them.

During the dinner session of the Board, one of the Interim Meeting speakers for the meeting the next day from Dallas, Texas, was introduced and spoke briefly. Due to the lateness of the hour, it was decided that unfinished items on the agenda should be carried over to the next meeting of the Board scheduled for Thursday, June 6, in Louisville.

Fourth Meeting—The fourth meeting of the Board of Trustees was a special called meeting held in Lexington, Sunday, April 21, at the Phoenix Hotel. The purpose of the meeting was to hear a report on the fast-moving developments relating to the disposal of the UMWA Hospitals in Eastern Kentucky by the Chairman of the Committee, James B. Holloway, M.D., Lexington; also, to hear the comments of Mr. Robert Barrie of the Presbyterian National Board of Missions of New York. Also present was F. J. L. Blasingame, M.D., executive vice-president of the American Medical Association.

Other guests included physicians representing the counties in Eastern Kentucky where the proposed transfer of hospitals would take place.

Subject matter considered included formation of new medical groups; housing of these groups in the hospitals; open staff requirements; agreement the Presbyterians would have with the UMWA on payment care; budgetary problems; discussion of the urgency of completing the agreements, method of government-made grants; eventual goal of the hospitals; insistence on free choice of physician and hospital and the fee for service principle.

Following a lengthy discussion in which there was broad participation, the Board went into executive session and passed the following motion: . . . "the Kentucky State Medical Association wishes to commend the Presbyterian Church for their humanitarian effort to keep these hospitals in operation. Furthermore, we feel that the members of the KSMA will provide medical care to the patients in these hospitals provided:

1. That the patient has free choice of hospital and physician
2. That medical service be on a fee for service basis
3. That there are no physicians offices in these hospitals

The Board of Trustees of the KSMA stands ready to cooperate in the future with the concerned partices in implementing this program in keeping with the above policies."

Fifth Meeting—The Board of Trustees of the Kentucky State Medical Association met on June 6 in the Board Room of the headquarters office in Louisville.

After learning that the members of the Johnson, Pike, Perry, Letcher, Floyd and Magoffin County Medical Societies had extended an invitation to the association to hold its 1964 Interim Meeting at the Jenny Wiley State Park at Prestonsburg, the Board unanimously voted to do this on Thursday, April 23, 1964.

The Board accepted a proposed expense report form for members traveling at the association's expense, which was prepared by the association's auditor and which will be acceptable to the Internal Revenue Service.

The Board also provided for the procedures that members traveling to national meetings at association expense shall follow in reporting on their activities.

Recommendations of the KSMA Memorials Commission were considered and approved. These recommendations included providing the mechanism for contributions in certain areas at the headquarters office.

After hearing the Reverend Dr. Paul B. McCleave, director of the AMA's Department of Medicine and Religion, explain the AMA's recommendation, the Board unanimously voted to appoint such a committee in Kentucky and named the five members of the committee it has requested to carry on the work.

The chairman of the Budget Committee presented the recommendations for the budget for the 1963-64 associational year, after explaining that these recommendations had been drafted in a day-long meeting of the Budget Committee and considered at length by the Executive Committee of the Board. After discussion, these recommendations were approved without dissent. The Board then considered the proposal of the KSMA Advisory Commission to the Blue Shield for the formation of what is to be known as the KSMA Insurance Review Board.

It was indicated that the formation of the Insurance Review Board would provide physicians a method of combating inflated medical fees, would give the insurance industry protection, as well as the physicians protection from certain insurance companies.

Following discussion and certain minor amendments, the Board passed the motion calling for the implementation of the recommendation. At this point, developments in the negotiations between the Presbyterians and the United Mine Workers hospital chain were discussed, and Governor Bert T. Combs appeared before the Board.

Following the governor's presentation, the Board

of Trustees passed the following motion: "We are gravely concerned about the abandonment of the hospitals in Eastern Kentucky by the UMWA. We now express our support of appropriate legislative efforts by the State Government to insure continued operation of these hospitals so that the urgent hospital needs of our distressed people in the Appalachian Mountain area might be met."

In a second motion the Board expressed appreciation to Governor Combs "for his diligent efforts in the very important matter of keeping these hospitals open."

The Board then heard the chairman of various trustee district grievance committees report on activities in their district. The Board then voted not to act favorably on bids to provide linings for the drapes in the Board Room at the headquarters office.

The Board unanimously voted to send congratulations to Fred C. Rainey, M.D., Elizabethtown, who has recently been elected as the new president of the Kentucky Junior Chamber of Commerce.

The Board voted upon a recommendation of the Kentucky Society of Anesthesiologists to place one of its members on the Infant and Maternal Mortality Committee.

Sixth Meeting—The sixth meeting of the KSMA Board of Trustees was held at the headquarters office, August 8, with Keith P. Smith presiding.

Robert C. Long, M.D., recently elected as a member of the Board of Trustees of the AMA was heard briefly and the reports of the President, the Delegates to the AMA, and the headquarters office were given.

A special request from the Campbell-Kenton County Medical Society was considered and the Board officially thanked the Kentucky Surgical Society for its annual one thousand dollar contribution to the McDowell Home Fund.

The final report of the Budget Committee, including its recommendations, were presented by the Chairman of the Committee, Douglas E. Scott, M.D., trustee from the Tenth District. (Inasmuch as the Board of Trustees will make a special recommendation to the House of Delegates on the action taken at that time, here tonight, details of the proposal will not be given here.)

The recommendations of the KSMA Memorials Commission to establish life memberships was considered and no action was taken pending the obtaining of a ruling from the Internal Revenue Service.

At the June 6 meeting of the Board of Trustees, as previously indicated, the activation of an Insurance Review Board for the association had been authorized. At the August 8 meeting, personnel for the Board was considered and the following men were elected to serve: Jack Chumley, M.D., Louisville, chairman; Bernard J. Baute, M.D., Lebanon; Harvey Chenault, M.D., Lexington; John Dickinson, M.D., Glasgow; Robert S. Irving, M.D., Louisville; Paul H. Klingenberg, M.D., Covington; and Alfred O. Miller, M.D., Louisville.

A letter signed by twenty-one members of the Bell County Medical Society relating to the future operation of the UMWA Hospital in Bell County and the location of the physicians' office was read and discussed.

Following much discussion, the Board reaffirmed its position in this matter that it had taken at the special April 21 meeting which is as follows:

1. That the patient has free choice of hospital and physician
2. That the medical service be on a fee for service basis, and
3. That there be no physicians offices in these hospitals

The Board devoted several hours to hearing the recommendations of the councils, the committees to the councils, and the standing committees. Board action on the recommendations of each of these committees and councils will appear at the conclusion of their reports.

The Board passed a recommendation made by the Committee to Study the Constitution and Bylaws that the six councils of the association give some study to delineating the duties of the committees under each council and reporting to the Board. The Board would then turn this over to the Bylaws Committee, which would attempt to frame appropriate Bylaw changes.

Keith P. Smith, M.D., Corbin, Chairman
KSMA Board of Trustees

Addendum

Recently expanded programs that have been authorized by the association have, of course, increased the cost of its operation. This, together with recent losses of revenue from another source, has caused an unbearable strain on our budget.

Because of these facts this House of Delegates will be asked to find additional revenue. A special committee will report to you on this at the first meeting of the House.

Recommendations, Reference Committee No. 1

Reference Committee Number 1 recommends acceptance of this report of the Board of Trustees and wishes to commend him and his fellow trustees for their diligence throughout the year and especially to commend them on their stand in reference to the operation of hospitals.

Mr. Speaker, I move the acceptance of this section of the report. (Motion seconded; carried.)

Report of the Secretary

It has been customary for your secretary to point out in his report to you each year some of the top accomplishments during the associational year that the report covers. With your permission this year we would like to deviate from this practice because of two reasons. First, your perusal of the House of Delegates envelopes will demonstrate to you that the 1962-63 associational year has been perhaps the busiest year in our 112 years of existence. And, second, this is my final report to you inasmuch as my term of office expires, and it is my firm belief that it is time for me to step aside.

So, with your permission, we would like to reminisce for a few minutes and point to some of the highly important developments in this association since I first became treasurer from 1946 to 1958. In 1956 I was elected secretary and editor of the Journal to fill out the unexpired term of Bruce Underwood, who resigned that position at that time. At the expiration of this term upon my recommendation, the office of secretary and editor was divided, and a new editor was elected, a new treasurer was elected, and I have served as your secretary since 1958.

First I would like to express to you my deep and lasting appreciation for the confidence you have placed in me, for the many honors that you have bestowed upon me and for the opportunity that you have given me to serve in these different offices.

For slightly more than fifty years prior to 1956, it was traditional for the secretary and editor of KSMA to be the secretary of the State Board of Health and Health Commissioner. In 1956 the separation was made complete. In the late 40's there was a growing feeling among the members of the association that it should expand its services to the members and the public and broaden its interests in socio-economic and political areas. This feeling crystallized late in 1949 when the Council (now the Board of

Trustees) voted to expand the association's services and establish a headquarters office. In order to improve communications within the association, a monthly newsletter was established at that time.

In 1950 the association implemented the action to establish a headquarters office. An Executive Secretary and Field Secretary were employed for the first time. The same year the association became the fifth state medical association to establish a state-wide grievance committee.

In 1951 on its hundredth birthday, the association developed its first budget, became the first state medical association to promote a state-wide diabetes detection program, and held its first interim meeting. (Then known as the county society officers conference.) This meeting has been held each year since and has been a most profitable activity.

In 1952 the Hospital Licensure Act, with strong support from the association and the State Department of Health, passed the legislature after many efforts in previous legislatures. The association voted to organize and support the Rural Health movement and was one of the organizing groups of the Allied Council on Medical Services.

In 1953 the association voted to conduct an indigent medical care survey which was subsequently used as a basis for the bill that was eventually passed and formed the basis for the present indigent care program.

In 1954 the association voted to nominate its members for only two consecutive terms on the State Board of Health. Prior to this time the association had not put any limit on this matter. The same year the association was honored when W. I. Greenwell, M.D., a former member of the Board of Trustees at New Haven, was elected by the American Medical Association as the outstanding General Practitioner of the year.

In 1955 the association became one of the first states to establish the practice of holding a Senior Day program designed to help the senior medical student make the transition between academic medicine and the actual practice of medicine, and this practice has been continued.

In 1956, as previously indicated, the separation of the officers of the State Board of Health and the Kentucky State Medical Association was made complete. This did not in any way, however, influence the practice or the desire of the association to fully cooperate with the State Board of Health.

In 1957 the association moved into the new Medical Arts Building on Eastern Parkway after it became apparent that the State Board of Health and the State Department of Health would be moved to Frankfort.

In 1958 the association established the practice of entertaining its congressmen and senators with a dinner in Washington. This Annual Dinner has done much to bring the members of the association and our national legislators close together.

In 1959 the first athletic injury prevention conference was held, and this practice has grown and expanded its usefulness to the coaches and school administrators in the state. During the House of Delegates meeting that year a committee was appointed to study the possibility of erecting a headquarters office for the association.

In 1960 the association's bill to establish an indigent care program finally passed the legislature. Another very important and controversial measure was the cancer-quackery bill that passed. At the meeting of the House of Delegates that year, it approved without a dissenting vote the recommendations of the committee to study a new home to purchase land and erect a headquarters building.

In 1961 the House of Delegates authorized the establishment of a political action committee for medicine in Kentucky. Since that time you have heard much about this committee and the effective work it has done. In addition, the association established a Highway Safety Committee and became active in a program in support of the State Department of Safety.

In August of that year, for the first time the association sent a delegation to Washington to testify against the first King-Anderson Bill in the 86th Congress.

In 1962 the association supported a mandatory immunization bill which passed the legislature. The Headquarters staff moved into its new office on January 26 and Governor Combs and the President of the AMA participated in the dedication of the new building on May 22.

In 1963 one of the highlights of the association's accomplishments was the development of the Insurance Review Board, establishing its procedures and activating this new group which will give the public and the profession governmental agencies involved in providing medical care and the insurance people a recognized, official group to study disagreements within this area; a place to be heard concerning disagreements and allegations of complaints and overutilization.

These are just a few of the many accomplishments that have taken place within the association that we may all take pride in. In the last 13 years the Journal of the KSMA has been steadily improved and at the two most recent biennial conferences of medical editors in Chicago, it was adjudged among the top ten of the Journals in that group. Advertising revenue climbed from some $10,000 in 1951 to almost $49,000 in 1960. Since that time, because of governmental regulations and the thalidomide incident which you will hear more about in this meeting, revenue has fallen off substantially. The Board of Trustees have given the editor and his Advisory Committee an opportunity to see if expenses of the Journal can be reduced without too much of a reduction of its content.

Another outstanding improvement in the association during the past decade has been its Annual Meeting. Physician attendance at this session has increased more than 300 percent and this is due primarily to the interest that the younger physicians are now taking in our Annual Session and to the excellent work that our Council on Scientific Assembly is doing in preparing for the scientific program and other phases of the meeting. Moreover, revenue from sales of exhibit space has increased approximately 400 percent.

At the national level the association has received increasing recognition as witnessed by the election in June of our senior delegate, Robert C. Long, M.D., as a member of the AMA Board of Trustees. In addition; some of our special publications have been recognized and distributed by the AMA to all other state medical associations. Among these are our Legislative Key Man manual, which was described as a model for legislative action for state medical associations; several exhibitor promotion flyers and other publications. A member of our headquarters staff is now serving on the Board of the Medical Society Executives Association, a national organization of some 350 members; the Board of Directors of the Professional Convention Managers Association and this year is acting as conference chairman for the national medical editors meeting, October 21 and 22, in Chicago.

The expansion of your headquarters staff, as other reports in your envelope show, has enabled the association to be represented at many organizations that have interest in health matters. These form valuable two-way communication contacts from which the association profits.

Gentlemen, we believe that you will agree with me that this brief report demonstrates the wisdom of the Board of Trustees back in 1949 in expanding the services of the association to the profession and the public. This progress could not have been realized except for the wisdom, dedicated and sacrificial ser-

vice. that your leaders have provided during this period. While we still have a long way to go, we think we have very much to be proud of.

To me, the one most outstanding single factor in which we can take pride is the progress that has been made in leadership from virtual one-man direction during the first fifty years of the century. Members of the profession have recognized their responsibilities, assumed duties and provided leadership that is indeed heartening.

Before closing this report, I would like to make one recommendation to the House of Delegates. Except for the office of secretary and the office of treasurer, no officer of the association can be elected for more than two consecutive terms. I would propose that the Bylaws be amended to limit the term of secretary and the term of the treasurer to two three-year periods. This is in keeping with the policy of the Board of Trustees to bring in new leadership and keep the officers of the association as responsive as possible to the times and the will of the profession. In looking to the future, we would like to adjure you as members of the House to recall that there are elements within our society who are becoming increasingly active and bold in our national and state legislative halls who would change our free enterprise system and who would alter the practice of medicine as we know it today. To combat this, we must give an increasing amount of our resources, our effort and our time. We owe this to the people and to the generations of physicians to come.

In closing, let me emphasize my deep appreciation for the consideration and recognition that you have given me the past 17 years. For all of these honors and the opportunity to work with this body and the Board of Trustees, I shall always be grateful.

Woodford B. Troutman, M.D., Louisville
Secretary

Recommendations, Reference Committee No. 1

Reference Committee Number 1 recommends acceptance of that portion of this report not referred to other committees and wishes to thank Doctor Troutman for his many years of service in this and other capacities and commends him for a job well done.

Mr. Speaker, I move the acceptance of this section of the report. (Motion seconded and carried.)

Report of the Editor

The Journal appears to have had a very successful year. Circulation is maintained at a level of about 3,000. It has been the policy of the Editor to encourage distribution of the Journal as widely as possible, particularly on an exchange basis to other accredited Journals and to libraries of Medical Schools. Any requests for exchange with foreign publications are considered, and are honored wherever it seems appropriate. This policy adds somewhat to the financial strain under which the Journal is now laboring, but by carefully screening the applications for exchange copies we feel the policy heretofore adopted remains logical and wise.

Some curtailment in the amount of scientific material carried has been necessary because of an appreciable decline in advertising copy used. It is our information however that this Journal has maintained better financial balance with regard to advertising than many similar medical publications.

After long and careful deliberation a new design for the cover of the Journal was adopted with the June issue of 1963. This seems to have met with general approval.

Sam A. Overstreet, M.D., Louisville, Editor

Recommendations, Reference Committee No. 1

Reference Committee Number 1 recommends the acceptance of this report and wishes to commend Doctor Sam for his usual excellence of performance as Editor-in-Chief of the Journal of the KSMA.

Mr. Speaker, I move the acceptance of this section of the report. (Motion seconded; carried.)

Report of the Treasurer

Reference Committee No. 1 recommends the acceptance of this report and wishes to commend Doctor Clardy on the completeness and clarity of his report. Full report of the Treasurer is available to members in the headquarters office.

Mr. Speaker, I move the acceptance of this section of the report. (Motion was seconded and carried.)

Report of the Delegates to the American Medical Association

The delegation to the AMA from the KSMA herein submits its annual report. The House will recall that the proceedings of the House of Delegates of the AMA at both the Interim Meeting and the Annual Meeting are published in some detail in The Journal of the KSMA. The object of this report, therefore, is to bring to the attention of this House the most significant actions of the AMA's House of Delegates.

At the Interim Meeting in Los Angeles, California, November 25-28, 1962, the following matters were acted upon:

1. Reaffirmation of Kerr-Mills Support and continued opposition to King-Anderson type of legislation. In addition, four suggested amendments to the Kerr-Mills Law were approved and four proposed amendments to the Internal Revenue Code designed to assist in financing the medical and hospital expenses of the aged were also approved.
2. In regard to medical ethics, action on new opinions submitted by the Judicial Council on physician ownership of drug stores, drug repackaging houses and drug companies and dispensing of glasses by ophthalmologists were postponed until the Annual Meeting.
3. In regard to Medical Education and Hospitals, a highly controversial report on compensation of residents and interns was submitted for information only with final action to be taken at the Annual Meeting. The House did approve, however, a recommendation that at least 25% of residents and interns of a hospital had to be graduates of an accredited U. S. or Canadian medical school as a requirement for accredited internship and residency.
4. Delayed action on the enlargement of the Board of Trustees until the Annual Meeting because of a misinterpretation of the Constitution and Bylaws. Physician registration was 5,209.

At the Annual Meeting in Atlantic City, New Jersey, June 16-20, the following matters were acted upon:

1. Establishment of a new Institute for Biochemical Research to be operated by the AMA Education and Research Foundation. The Institute will concern itself with intensive and fundamental study of life processes particularly as related to intracellular mechanisms.
2. Approved the establishment of an AMA physicians' pension plan under the provision of the Keogh Law. The plan will be open to all AMA members and their employees who can qualify under the Act.
3. Deferred any definitive statement regarding the relationship of tobacco and disease and recommended that the AMA continue its study of this matter.
4. Disapproved the report of the Council on Medical Service and the Council on Medical Education and Hospitals on compensation of House Officers.

5. Rescinded its action relating to the "25% rule" of interns and residents.

6. Approved a Judicial Council opinion that physician ownership of drug stores is not unethical "provided there is no exploitation of his patient," and that ownership of drug repackaging houses and pharmaceutical companies is unethical.

7. Disapproved a Judicial Council opinion that dispensing of glasses by ophthalmologists is unethical.

8. Elected Norman Welch, M.D., of Boston, Massachusetts, president-elect of the AMA. He will succeed Edward R. Annis, M.D., of Miami, Fflorida, in June 1964.

9. Approved enlargement of the Board of Trustees from 11 to 15 members by adding three elected trustees and including the immediate past president for a one-year term. Terms of office for the trustees was reduced from 5 to 3 years and the number of terms limited to 3 for a maximum total of 9 years service. In addition, one vacancy existed on the Board of Trustees. A Kentucky physician was elected to fill that vacancy.

Finally, the delegates and alternate delegates, J. Vernon Pace, M.D., Wyatt Norvell, M.D., John Quertermous, M.D., Carl Cooper, Jr., M.D., and J. Thomas Giannini, M.D., join with me in expressing our warm thanks and deep gratitude for the assistance of the many Kentucky physicians and their wives who were so very helpful to us on conducting the business of the delegates. We also wish to thank Joseph Sanford and his fine staff for their invaluable assistance.

Robert C. Long, M.D., Louisville
Senior Delegate to the AMA

Recommendations, Reference Committee No. 1

Reference Committee Number 1 recommends the acceptance of this report and wishes to commend the work of the delegates to the AMA and especially to compliment Doctor Long for his efforts which have not gone unnoticed, as shown by his election to the Board of Trustees to the AMA.

Mr. Speaker, I move the acceptance of this section of the report. (Motion seconded; carried.)

Report of the Executive Secretary

The purpose of this report is to give you a quick and very brief look at the varied responsibilities that your Headquarters Office staff seeks to fulfill. With the continual expanding of programs and services offered by the agencies of the association, the work of the headquarters staff shows a corresponding increase in volume.

Activities of the members of your KSMA headquarters staff fall into three broad categories:

First: Implementing policies and directives of the House of Delegates, Board of Trustees, officers, councils, and committees.

Second: Administrative and housekeeping.

Third: Publications, exhibits, and promotion.

Under the first classification we would like to explain that there were a total of 79 official trustee, executive committee, council, and standing committee meetings held during the year, not including the month of September, when this annual session takes place. These meetings involved approximately 600 physicians who spent 2097 hours and traveled 87,850 miles in serving the members of the association and the public. This represents close to a 10% increase in association activities over the 1961-62 associational year, which is a matter in which members of the association can take pride.

Staff responsibilities include working under appropriate authority to set up meetings, agendas, keep minutes, and, more important and time-consuming, implementing the actions of these groups.

As impressive as the above figures are, they do not include activities by members of the staff that are carried on in connection with the regular meeting of the House of Delegates, The Annual Meeting, the Interim Meeting, Senior Day, the Rural Health Conference, the regular 7:30 Monday morning meeting of the editors in the Headquarters Office, or the numerous consultations that members of the staff have with KSMA officers, council and committee chairmen.

Not mentioned above is the work of the staff in assisting the 15 district trustees in setting up meetings, promotional activities, committing speakers; in addition, carrying out the work incident to the responsibilities under the Rural Scholarship program, the Physicians Placement Service, and the assistance rendered the Student AMA and KSMA.

Under the second category of Administration and housekeeping are a multitude of less dramatic activities, but which constitute a very important part of the staff's obligations. These include maintaining financial records, membership records (membership in KSMA and AMA is at an all time high), close liaison with 119 county medical societies, purchasing, correspondence, filing, care of the building and grounds. Other activities under this category include referring of grievances, providing information on ethics, laws pertaining to health matters, requests for information from insurance companies, general information required by members, arrangements and promotion of the congressional dinner in Washington, D. C., and maintaining active liaison with the Woman's Auxiliary to KSMA.

Without going into all the administrative responsibilities of the Annual Meeting, we can give you an idea of what is involved when it is pointed out that we have personally made arrangements for approximately 60 business, scientific and social meetings for our own association and cooperating groups with this hotel for this meeting.

The third category of our activity includes publications, presentation of exhibits and general promotion. The Journal of KSMA is the most important of all of these. With the exception of scientific articles, editorials, and certain departments, all of the writing that appears in the Journal is done by the staff. In addition, it must gather and coordinate this material and meet the deadline each month. The staff, under appropriate supervision, collects the material and writes two monthly newsletters and processes them. Other publications include frequent news releases, special leaflets, and pamphlets designed for specific uses.

In the area of exhibits, the association has expanded this phase of its activities of health education. These included exhibits at the Kentucky State Fair, the Kentucky Educational Association, annual meeting of school boards, and other lay groups. This is done under the supervision of appropriate KSMA councils and committees.

The promotional activities of the staff are varied, time-consuming and necessitate considerable travel. These include the promotion of various phases of legislative programs, problems relating to cults, promoting of athletic injury conferences, highway safety programs and civil defense. More recently, activities have been carried on in connection with the transfer of hospitals in the eastern Kentucky area. Many of these efforts involve working and travelling with members of the association.

Still another phase of staff activity involves representing the association at committee and other meetings in which the association has a related interest and which presents an opportunity to obtain information of interest to medicine and at the same time reflect medicine's point of view. Included in the sizeable group of meetings thus attended, are such things as public health, government, rural health, and indigent care programs.

In an effort to keep up with developments at the regional and national levels, the staff attended 40 meetings during the past year. Many of these were sponsored by the AMA in the areas of legislation, voluntary health insurance, communications and public service activities.

Our association received national recognition when the First Regional Medical Society Executives Association Conference was held at the Headquarters Office in May. Some fifty-odd state and county medical society executives from surrounding states attended this meeting which was approved by the Board of Trustees.

The Journal of KSMA was honored when your Executive Secretary, who serves as Managing Editor of the Journal, was asked to serve as conference chairman for the biennial meeting of all state medical journal editors in Chicago this October 21 and 22.

We would be derelict in our duty not to express the appreciation of our headquarters staff to the association for the opportunity of carrying out our activities in the new quarters that were provided for us and which were occupied some twenty months ago. It can be safely estimated that this carefully planned facility has increased the staff's productivity between 15 and 20 percent. If any of you have not had an opportunity to inspect the new headquarters building, the staff would be most grateful for the opportunity of showing you through the building.

It is always difficult for us to find the appropriate wording in this report to express our appreciation to the members of the House of Delegates, Board of Trustees, councils, committees, and officers for the opportunity of working with you. We are more than grateful for your tolerance of our short-comings, for your cooperation, and many acts of consideration.

We want to especially express our gratitude to our President, the Chairman of our Board of Trustees, the Speaker of the House, our Secretary, Treasurer, and Editor for their excellent leadership and for the time and consideration they have given us.

To the other nine members of our Headquarters Staff I wish to express my unlimited appreciation for their splendid performance during the year and for the dedicated manner in which they have discharged their obligations.

J. P. Sanford, Louisville
Executive Secretary

Recommendations, Reference Committee No. 1

Reference Committee Number 1 recommends the acceptance of this report and wishes to express our appreciation to Mr. Sanford for his usual excellent performance of a difficult job.

Mr. Speaker, I move the acceptance of this section of the report. (Motion was seconded and carried.)

Resolution H

Harlan County Medical Society

WHEREAS, throughout Kentucky and the rest of the United States, there is an acute shortage of Allied Medical Personnel; and

WHEREAS, this shortage is predicted to increase; and

WHEREAS, Allied Medical Personnel are essential if we are to maintain medical care at a high level; and

WHEREAS, there are ever increasing numbers of young people seeking satisfactory job opportunities; and

WHEREAS, the Woman's Auxiliary to the KSMA and the members of its component Societies have been promoting and directing the organization of Allied Medical Career Clubs throughout the State and stimulating many young people to pursue their studies in various Allied Medical Careers, now therefore be it

Resolved, that the KSMA

1. Commends the members of the Woman's Auxiliary to the KSMA for its work in this field.
2. Offers to cooperate, assist and work with the Woman's Auxiliary to the KSMA in this essential project and directs the President of KSMA to appoint a committee to work with the Auxiliary toward these ends.
3. Directs the delegates from the KSMA to the AMA to introduce resolution(s) at the next meeting of the House of Delegates of the AMA calling for the establishment of a commission to study all aspects of this problem and make recommendations to the House of Delegates designed to increase manyfold the number of people seeking training and job opportunities in Allied Medical Careers.

Resolved, further that copies of this resolution be sent to:

1. Chairman, Resolution Committee KSMA
2. President, Woman's Auxiliary to KSMA
3. President, Woman's Auxiliary to Harlan County Medical Society

Recommendations, Reference Committee No. 1

The subject of this resolution is commending the Woman's Auxiliary to the KSMA. Reference Committee Number 1 accepts this resolution and refers it to the Board of Trustees for appropriate action.

Mr. Speaker, I move the acceptance of this section of the report. (Motion was seconded; carried.)

Mr. Speaker, I move the adoption of this report as a whole. (Motion was seconded and carried.)

Reference Committee No. 1

Ballard W. Cassady, M.D., Pikeville, Chairman
Walter R. Byrne, M.D., Russellville
Guy C. Cunningham, M.D., Ashland
Paul J. Ross, M.D., Louisville
George H. Widener, Jr., M.D., Paducah

REFERENCE COMMITTEE NO. 2

Kenneth M. Eblen, M.D., Chairman
Reports on Scientific Assembly and
Medical Education

Reports of the Council on Scientific Assembly

Preface

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the Bylaws which reads in part:

". . . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Scientific Assembly is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each committee report.

3. Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.

* * * * * *

The Council on Scientific Assembly met November 8, 1962, at the KSMA Headquarters Office. The Council reviewed the results of the 1962 Annual Session held in September and observed that it was among the best attended that KSMA has held. It was decided that the "symposia in depth", undertaken as a feature of the general scientific session had been well received.

The Council reviewed other procedures of the 1962 session, and then turned to considering policies for the 1963 session. It was decided to follow the symposia in depth approach to programming the 1963 scientific session and the Committee on Scientific Program was so authorized.

The Council was pleased that the 1963 meeting would again present closed circuit color television, under the sponsorship of Smith, Kline & French Laboratories of Philadelphia. The Council noted that the 1962 Trans-Atlantic CPC, also sponsored by SK&F had drawn a standing-room-only audience.

Since the 1963 meeting was to be held at the Phoenix Hotel in Lexington, plans were approved for the organizing of facilities to meet our needs. It was decided to hold certain specialty group meetings simultaneously with the general session where no conflict in subject matter existed.

The Council wishes to express its appreciation to the various committees and their chairmen of this council for the splendid cooperation in developing the 1963 meeting.

The following reports of the committees serving under the Council are herewith submitted.

Recommendations, Reference Committee No. 2

Our committee wishes to commend the Council on Scientific Assembly for their hard and diligent work in preparation for the 1963 KSMA meeting. We want to specifically commend them on once again being able to present us with the closed circuit color television, and we wish to join the membership in thanking Smith, Kline and French Laboratories for sponsoring this television program.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Scientific Program Committee, Edmund D. Pellegrino, M.D., Lexington, Chairman

The associational year just closing has been an unusually busy one for the Committee on Scientific Program. Two well attended meetings of the Committee were held in planning and developing the program. Your chairman in addition, attended numerous meetings of cooperating groups.

It was decided to follow the same pattern in constructing the 1963 scientific program for the general session which was initiated at the 1962 meeting. The general approach of this plan is to develop a half-day program in considerable depth around a basic problem or subject.

The full cooperation of the specialty groups and their officers is necessary to accomplish this. We met with the presidents of the cooperating specialty groups in a special meeting in Lexington in order to explain how the plan operates. Their support has been most encouraging.

One of the features of this year's general session is the use of closed circuit television. For the first time in our state, a panel will be located in the room with the audience and the audience will hear the two-way conversation panelists will carry on with physicians who are with the patient in the broadcasting studio located in the Medical Center on the University Campus. This, plus improved equipment, should make these programs much more valuable to you.

Few appreciate the amount of work incident to developing the approximately four hours of color television programs that have been scheduled. Our committee would like to thank the staff of Smith, Kline and French Laboratories and the many participating physicians for their splendid contribution in time and effort that have gone into what we believe will be an excellent program.

Our committee would like to thank our guest speakers, the specialty group presidents, the hard-working participants in the television programs and the Smith, Kline and French people's dedicated efforts in helping us bring to you a highly practicable program.

Recommendations, Reference Committee No. 2

The committee wishes to commend Doctor Edmund Pellegrino and his committee for the long hours they spent in preparation of the program they have planned, with special emphasis on the great deal of work involved in the planning of a lengthy program around a basic problem or subject.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Scientific Exhibits Committee, Benjamin B. Jackson, M.D., Louisville, Chairman

The Scientific Exhibits Committee composed of Benjamin B. Jackson, M.D., chairman; Richardson K. Noback, M.D., and Thomas R. Marshall, M.D., will meet July 18 to review applications for scientific exhibits for the Annual Meeting of the Kentucky State Medical Association. As of July 10, 1963, thirteen scientific exhibit applications had been received.

This year the area for the exhibits will be The Stephen Foster Room and The Breckenridge Room in the Phoenix Hotel, Lexington. All exhibits are to be in place by 8:00 a.m., Tuesday morning, September 24 and are not to be removed until 3:30 p.m., Thursday, September 26.

A committee to be named prior to the Annual Meeting will judge the exhibits during the first day of the meeting so that proper notification of the winner can be made during the early part of the program. A certificate of appreciation, signed by the KSMA President and the Chairman of the Board of Trustees, will be given to each exhibitor as in the past.

The Scientific Exhibits Committee would like to take this opportunity to restate its long-standing policy:

1. Scientific Exhibits are a part of the KSMA Continuing Medical Education Program and were initiated for the sole purpose of presenting scientific material.
2. Scientific Exhibit application may be accepted only from an individual physician or group of physicians unless other stated herein.
3. No applications may be accepted from any commercial organization or physician whose exhibit bears the name of a commercial organization.
4. Space will continue to be made available for the State Department of Health to use as it deems best.
5. The Committee on Scientific Exhibits may and should approve applications, when space is available, from other state or non-profit agencies, when these agencies are cooperating with special programs of KSMA committees that are in the public interest.
6. The Committee on Scientific Exhibits may make

space available to either of the state's two medical schools if there is sufficient space and if the committee members think the exhibit would make a contribution to the KSMA membership.

7. KSMA will provide space, sign for booth, current and bracket lights for the exhibitor. All additional costs to include transportation, equipment rental, etc., will be borne by the exhibitor.

Recommendations, Reference Committee No. 2

The committee wishes to commend the Scientific Exhibits Committee under the direction of Doctor Benjamin Jackson for the long hours of work necessary in presenting scientific exhibits without deviation from the committee's long-standing policies for presentation of scientific material.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Technical Exhibits Committee, Clyde T. Moore, M.D., Fern Creek, Chairman

The Committee on Technical Exhibits is responsible for selecting, promoting, and presenting the technical exhibit hall at the Annual Meeting. It is pleased to report that the exhibitors have given substantial support to the idea of moving the meeting to Lexington, and we were unable to accept all applicants who qualified.

The Committee on Technical Exhibits believes the technical exhibit hall makes a very practical and worth-while contribution to our meeting. You are urged to visit each booth and learn the latest developments in pharmaceuticals, medical literature, equipment and services.

The same vigorous promoting has been given this meeting as other meetings in the past. Our committee will be most grateful for your spending as much time as possible in the technical exhibit hall. You will find the information you'll receive a valuable asset to your practice.

Recommendations, Reference Committee No. 2

Our committee is very conscious of the part that is played by the technical exhibitors, and we wish to commend Doctor Clyde Moore and his Technical Exhibits Committee for the number of exhibitors at our meeting.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Awards Committee, William H. Bizot, M.D., Louisville, Chairman

The KSMA Awards Committee has implemented plans to call to the attention of all individual members of the profession the value of the KSMA award program. This was decided at a meeting of the committee on March 7 in Covington.

The state was divided into five sections with an equal number of counties in each section. A member of our committee was assigned to each and asked to contact each county medical society in his section for the purpose of obtaining nominations for an association award.

The results of these efforts have produced more interest in award nominations than usual. The Awards Committee makes nominations for the KSMA Distinguished Service Medal and the Outstanding General Practitioner Award.

As a result of policy set by the House of Delegates, the R. Haynes Barr Award for outstanding contribution to the health field by a layman is selected by the Awards Committee. Citations for these awards will be presented at the President's Luncheon, September 25, during the Annual Meeting.

Our committee wishes to express appreciation for the cooperation we have received.

Recommendations, Reference Committee No. 2

The committee wishes to thank Doctor William Bizot and his Awards Committee for the time they have spent in considering the nominations for each award and the choices they have made.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Golf Committee, Kenton D. Leatherman, M.D., Louisville, Chairman

The KSMA Golf Committee has met once during the past year on May 15 in Lexington.

It was taken by common consent that the 1963 Golf Tournament would be conducted in the same manner as past tournaments with the following exceptions:

(1) Handicaps will be determined by the Bankers System which gives all participants an equal opportunity of winning the tournament.

(2) Permanent trophies will be awarded to the winners in lieu of traveling trophies.

The 1963 tournament will be held at the Lexington Country Club and all Kentucky State Medical Golf Association members are urged to participate. The fee of $7.00 covers the greens fee, associational dues, and cost of the trophies and prizes.

Your Golf Committee has given serious consideration to the following:

(1) That a number of persons having brought to our attention the desirability for a period of time to be set aside at the Annual Meeting for recreational purposes only—for all those attending the meeting.

(2) That in the past there has been competition between the KSMA Golf Tournament and scientific sessions.

(3) That attendance at the Annual Meeting would be increased by offering recreational time and planning and promoting a better golf tournament which would be held one afternoon only rather than scattered daily throughout the meeting.

(4) That there appears to be a trend for medical groups to set aside one afternoon at Annual Meetings for recreation, at which time no scientific sessions are scheduled.

The KSMA Golf Committee recommends that one designated afternoon be set aside for golf and recreational activities during the Annual Meeting of the KSMA as a part of the Annual Meeting Program at which time no scientific sessions are scheduled and further recommends that this be implemented beginning with the 1964 Annual Meeting.

Recommendations, Reference Committee No. 2

The committee wishes to thank Doctor Kenton Leatherman and his Golf Committee for the work entailed in presenting our 1963 Golf Tournament. The committee whole-heartedly is in agreement with the Golf Committee and their recommendations for a period of time to be set aside in our Annual Meeting for recreation purposes only, and this includes our Golf Tournament. The committee feels the attendance at the scientific sessions would be increased and our tournament would be a much better one if the two did not conflict.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Council on Scientific Assembly

George P. Archer, M.D., Prestonsburg
Harvey Chenault, M.D., Lexington
Douglas M. Haynes, M.D., Louisville
Benjamin B. Jackson, M.D., Louisville
Clyde T. Moore, M.D., Fern Creek
Edmund D. Pellegrino, M.D., Lexington
David M. Cox, M.D., Louisville, Chairman

Recommendations of the KSMA Board of Trustees

The Board of Trustees reviewed this report on August 8, 1963. The report, including all recommendations, was approved without dissent.

Report of the Council on Medical Education and Hospitals

Preface

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the Bylaws, which reads in part:

". . . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Medical Education and Hospitals is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each committee report.
3. Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.

* * * * *

The Council on Medical Education and Hospitals has met twice during the associational year, December 6, 1962 and June 27, 1963. At its first meeting the Council discussed in detail the activities of the committees serving under the Council, and William R. Willard, M.D., Dean of the University of Kentucky Medical Center, presented a detailed report of some of the current projects and activities of the AMA Council on Medical Education and Hospitals. The committees serving under the Council are: Advisory Committee to U. of K., Advisory Committee to U. of L., AMA-ERF Committee, Continuing Medical Education Committee, General Practice Committee and Hospital Committee.

At its second meeting Homer Martin, M.D., Louisville, reported on an Osteopathic-Medicine meeting he attended in conjunction with the AMA Annual Meeting in June, 1963, as a representative of this Council. The Council has appointed a subcommittee consisting of Homer Martin, M.D., Chairman, J. B. Holloway, M.D., Lexington and Walter I. Hume, Jr., M.D., Louisville, whose purpose will be to study and report on developments as they occur in the area of medical-osteopathic relationships.

The Council has discussed in detail the relationship between the full-time faculty and the practicing physician and submits the following recommendations:

1. That the Advisory Committees to the state's two medical schools have greater representation from the local communities of Lexington and Louisville. The Council feels that serious consideration should be given to having the committee chairmen, in particular, from the local community.

2. The Council requests that the Deans of the two medical schools provide the KSMA Executive Committe with a list of faculty members that might be considered for appointment to KSMA committees. It is additionally recommended that the area of interest of each faculty member be submitted with this list.

3. The Council recommends greater use of the KSMA Journal as an area of common interest and communication between faculty members and practicing physicians. Such communication could include scientific contributions by faculty members, continuing medical education opportunities, special articles, a medical school page, etc.

4. The Council recommends that the Deans of the two medical schools encourage full-time members of clinical departments to participate to a larger degree in the medical community. It is suggested that in order to promote greater professional and social interchange between the full-time faculty and the community in which they reside, that all efforts to produce and have joint meetings should be encouraged, specifically staff meetings of both part and full-time staffs, and any other opportunities which present themselves for joint meetings between the two groups.

5. The Council requests permission to develop a questionnaire for the purpose of polling practicing physicians, clinical voluntary faculty members and full-time faculty members in Lexington and Louisville primarily, to develop an inventory of attitudes and concerns as pertains to the full-time faculty and practicing physician relationships regarding teaching, university hospitals, etc.

6. The Council recommends that the current position of the KSMA, pending the results of an AMA Task Force Study, be in opposition to any legislation aiming to regulate the use of animals in medical research. The Council plans to keep the matter of antivivisectionist legislation under constant study and make additional recommendations in the future.

7. The Council recommends that the Chairman of all standing committees of the Council on Medical Education and Hospitals automatically become members of the Council.

Additionally, at its second meeting AMA-ERF checks were presented to the Deans of the two medical schools as follows: University of Kentucky —$6,273.02 and University of Louisville—$13,096.-80.

The report of the committees covering their activities and recommendations follows.

Recommendations, Reference Committee No. 2

The committee considered the report of the Council on Medical Education and Hospitals in part and in toto.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Advisory Committee to the U. of K., O. Leon Higdon, M.D., Paducah, Chairman

As Chairman of the Advisory Committee to the University of Kentucky Medical Center, I wish to report to you that there has been no meeting for this Committee during the year.

The need for such a meeting has been discussed with various members of the Committee and with William R. Willard, M.D. It is possible that a meeting will be held before the next meeting of the Kentucky State Medical Association in September, 1963.

Council Action: It is recommended by the Council on Medical Education and Hospitals that the report of the Advisory Committee to the U. of K. be accepted as presented.

Recommendations, Reference Committee No. 2

That portion of the report dealing with the Advisory Committee to the University of Kentucky was accepted as presented. The committee noted that there had been no meeting of the Advisory Committee to the University of Kentucky this past year. The committee feels that this Advisory Committee to the University of Kentucky is an important one and that every effort for close liaison with the University

of Kentucky Medical Center and KSMA be maintained.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Advisory Committee to the U. of L., Lawrence T. Minish, Jr., M.D., Louisville, Chairman

No report presented.

Recommendations, Reference Committee No. 2

The committee noted that there was no report presented.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

AMA-ERF Committee, Walter I. Hume, Jr., M.D., Louisville, Chairman

This committee met on November 15, 1962, and explored the various possible methods of arranging contributions to the AMA-ERF Fund by Kentucky physicians. A letter was sent to the deans of the two Kentucky medical schools, and various methods were mentioned at a meeting of the Council on Medical Education and Hospitals on December 6, 1962. It was felt that, as a result of these discussions, it would be better to simply publicize the National Campaign for funds for this foundation rather than conduct any concerted drive in Kentucky, which it appeared would likely overlap alumni drives. This has been done during the past year.

Council Action: It is recommended by the Council on Medical Education and Hospitals that the report of the AMA-ERF Committee be accepted as presented, and the Council recommends that the AMA-ERF Committee and the Advisory Committees to the two medical schools establish liaison for the purpose of working out a combined program.

Recommendations, Reference Committee No. 2

The AMA-ERF Committee report was read and it is the recommendation of this committee that it be accepted as presented, specifically in view of the knowledge that this report would be handled at greater length by another committee.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Continuing Medical Education Committee, Walter S. Coe, M.D., Louisville, Chairman

The Continuing Medical Education Committee has met once during this associational year and a Subcommittee on Continuing Medical Education has held one meeting. We would like to invite your attention to a change in the name of the Postgraduate Medical Education Committee to the Continuing Medical Education Committee.

Since our last report, there have been considerable changes made in the staffing and the functions of the Continuing Medical Education Office, as required by the reduced KSMA allocation to the committee, which was approved by the House of Delegates at the 1962 Annual Meeting.

Reduction in the committee's budget has resulted in the termination of a full-time secretary and the position of Executive Director of the Continuing Medical Education Office.

The present duties of the office are now the responsibility of the KSMA Executive Assistant. An additional secretary was employed by KSMA, of which one-third of her salary is paid by the committee for a proportionate amount of time to be devoted to performing administrative duties for the committee.

The primary function of the Continuing Medical Education Office is now that of coordination, correspondence and maintenance of the Continuing Medical Educational Opportunities page in the KSMA Journal. At its meeting on November 27, 1962, the Continuing Medical Education Subcommittee noted that the University of Louisville School of Medicine, the University of Kentucky Medical Center and the Kentucky Academy of General Practice must keep in close liaison, in that these three institutions would be obligated to perform some of the functions that have been conducted in the past by the Continuing Medical Education Office.

One of the more important services rendered by the Continuing Medical Education Office is that of acting as a clearing-house and maintaining a calendar of all scheduled meetings. This valuable service to the profession insures notification of all meetings of interest to each KSMA member and eliminates the scheduling of meetings of similar interest on the same date. We urge that you read the Continuing Medical Educational Opportunities page in the KSMA Journal each month.

Close liaison with interested parties is supplemented by questionnaires mailed periodically to all specialty groups to maintain up-to-date information on all Continuing Medical Education programs. In order that we might serve you best, we urge the cooperation of all individuals, groups or institutions planning Continuing Medical Educational meetings, to report all meetings planned to the Continuing Medical Education Office.

In addition to promoting meetings in Kentucky and surrounding states, meetings of area interest are submitted to medical journals in neighboring states for publication.

Council Action: It is recommended by the Council on Medical Education and Hospitals that the report of the Continuing Medical Education Committee be accepted as presented, and the Council requests that the two medical schools and the Kentucky Academy of General Practice, if they are willing, to submit a report each year early in June, describing their program of continuing medical education for physicians, providing statistical information on enrollment, and any major program developments or changes.

Recommendations, Reference Committee No. 2

The reference committee read and considered at length the report of Doctor Walter Coe and his committee on Continuing Medical Education. As was noted in this committee's report, the primary functions of the Continuing Medical Education Office are being done by the University of Louisville School of Medicine, University of Kentucky Medical Center and the Kentucky Academy of General Practice. This committee feels that in view of the fact that the primary function of the committee is being performed by other agencies, that this committee be abolished. The committee felt that since the prime duty of coordination of medical education meetings as stated in the report were now the responsibility of the Executive Assistant, the members of this committee could be better utilized at other tasks.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

General Practice Committee, Homer Martin, M.D., Louisville, Chairman

In recent years the function of this committee has been to encourage improved and expanded education for the general practitioner so as to make the climate of practice more desirable. The committee met on May 9, 1963, in Louisville for a review of existing teaching programs and an exchange of ideas on the prevailing thought extant at the present time. The following conclusions were unanimously approved after a lengthy discussion by the members present:

1. The positive steps taken by our two medical schools to improve general practice are impressive,

but further efforts should be continued to establish programs which will attract physicians into this field and restore the balance among the specialties.

2. The present training period for general practice is too short. We believe that it is essential that the training be extended to at least two years following medical school and that emphasis in training be put on diagnosis (medical, surgical and pediatric), that a moderate amount of psychiatry be given, and that obstetrics not be neglected in any trainee but, in fact, should be extended for those doctors planning a rural practice. Very little time should be devoted to major surgery or occupational medicine as surveys, as well as personal experience, show these subjects to be of little practical use to the modern practitioner.

3. The plan for postgraduate residency training should be flexible and adjustable both to the student and his geographic locale. Further, it should be of a quality to make it acceptable for board certification.

4. Whether or not a medical school has a department of general practice is of secondary importance to achieving excellent training for future general practitioners. The mere physical existence of a department is not so desirable as an effort by *all* departments to further the education of general physicians.

5. The committee looks with disfavor on private hospitals which exploit interns and do not provide a proper teaching milieu. Medical school programs may lack some of the social advantages of a private internship and demonstrate less of the art of practice, but, by and large, vastly excel in their educational programs.

6. Kentucky has a peculiar dichotomy of thought in referring to city doctors as specialists and rural physicians as general practitioners. An even more undesirable dichotomy is one in the medical community which holds that all specialists are competent and general practitioners are not. The purpose of all efforts to improve medical education is to provide one high quality of medical care regardless of the action of the physician involved.

The decline in the number of general practitioners in the United States continues at a precipitous rate. Only through the development of an attractive program, qualitatively equal to other specialties, can we induce physicians to enter family practice. The beginnings of such programs are taking form in Kentucky's schools of medicine. Current attitudes toward education by active general practitioners is presented.

The committee recommends that the successor General Practice Committee continue its efforts to study, assist and encourage in all ways possible the actions by our two schools of medicine in their efforts to formulate adequate training programs, thereby creating a favorable climate for family practice.

Council Action: It is recommended by the Council on Medical Education and Hospitals that the report of the General Practice Committee be accepted as presented.

Recommendations, Reference Committee No. 2

The committee considered the report of Doctor Homer Martin and voted to accept the conclusions of the committee listed numbers 1, 2, 3 and 4. Conclusion number 5 was rejected by the committee in that it is felt that interns may be exploited in any internship whether it be in a private hospital or at a teaching institution. The committee also voted to reject conclusion number 6, feeling that it was irrelevant to the report and suggests that conclusion number 6 be deleted from this report.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Hospital Committee, James B. Holloway, M.D., Lexington, Chairman

The Hospital Committee met twice this year, March 21 and May 23. In addition, the Chairman of the Hospital Committee has made one two-day trip to Harlan to attend a meeting on the United Mine Workers Hospitals, has met with the KSMA Board of Trustees on two occasions regarding the United Mine Workers Hospitals and is planning a three-day trip on June 26th, 27th and 28th to Eastern Kentucky regarding the UMWA Hospitals. In chronological order, here are the activities of the committee and chairman during the year.

I. The Clinton County Hospital has required no more visits or action from this committee this year. We have received frequent reports and things seem to be in good order at that hospital.

II. "A Guide for Release of Information for Medical Records" was published by the Kentucky Hospital Association with the cooperation of this committee and was well received. In line with this, the chairman of the committee gave a talk before the Medical Records Librarian Association at the Kentucky Hospital Association meeting.

III. The committee received a number of letters regarding the staffing of the hospital at Morehead, Kentucky, which is opening in July of 1963. Louise Caudill, M.D., is planning to have some salaried positions with offices in the hospital. She has met with the Board of Trustees concerning this.

IV. We were consulted briefly about the closing of the hospital in Greensburg and offered our services. We have received no further communication since that time, but I understand from the paper that the hospital is opening in July, 1963, with a surgeon present.

V. In Franklin, Kentucky, a proprietary hospital, along with Carter Moore, M.D., is being sued by an insurance company. The committee again offered its services and the services of the Kentucky State Medical Association. We were not requested to come in any further.

VI. In Henderson, Kentucky, a situation came up where the hospital administrator chose to hire a hospital anesthetist and was going to dismiss physicians from the staff. Letters were written concerning this and with the cooperation of the Kentucky Hospital Association, this was cleared up satisfactorily so that the physicians maintained control of anesthesia and remained on the staff.

VII. The United Mine Workers Hospital situation certainly has been a most complex problem with which the committee has had to deal this year, and it is yet unsolved. Following the two-day meeting during January in Harlan, the chairman of the committee attended a second meeting in Lexington in April at which time E. D. Rosenfeld, M.D., the consultant for the Presbyterian hospitals, presented his facts. Following this, the Presbyterians elected to try to purchase the hospitals. The KSMA Board of Trustees then met in late April and approved the following resolution:

> . . . that the Kentucky State Medical Association wishes to commend the Presbyterian Church for their humanitarian effort to keep these hospitals in operation. Furthermore, we feel that the members of the KSMA will provide medical care to the patients in these hospitals provided:
> 1. That the patient has free choice of hospital and physician
> 2. That medical service be on a fee for service basis
> 3. That there are no physicians offices in these hospitals

The Board of Trustees of the KSMA stands ready to cooperate in the future with the concerned parties in implementing this program in keeping with the above policies.

Following this, the federal government approved a grant for the purchase of the hospitals in Harlan, Hazard, McDowell, Middlesboro and Whitesburg. A special session of the legislature was called, and I presume they will pass this bill.

The Chairman of the committee presented Governor Combs to the Board of Trustees at its June 6 meeting, and after Governor Combs' presentation, the Board approved the following statement.

"We are gravely concerned about the abandonment of the hospitals in Eastern Kentucky by the UMWA. We now express our support of appropriate legislative efforts by the State Government to insure continued operation of these hospitals so that the urgent hospital needs of our distressed people in the Appalachian mountain area might be met."

On June 26th, 27th and 28th, the Chairman of the committee is meeting with the Presbyterians, Doctor Rosenfeld, and the private physicians in Kentucky in five separate meetings at Pikeville, Harland, Hazard, Whitesburg and Middlesboro. We hope to be able to thrash out some satisfactory solutions so that the doctors in Eastern Kentucky will be on a cordial relationship with the Presbyterian Hospital group, so that medicine in Eastern Kentucky is de-socialized, and so that third party medicine is no longer present.

Addendum to the Report of the KSMA Hospital Committee

The purpose of this addendum is to report that a trip was made to Eastern Kentucky regarding the transfer of the UMWA Hospitals to the Appalachian Hospital Board. In attendance at these meetings, which were held on June 26, 27 and 28, were James B. Holloway, M.D. and Mr. Bobbie Grogan, representing KSMA; Mr. Hasty Riddle, representing the Kentucky Hospital Association; Reverend Gordon Corbett, representing the Presbyterian Board of Missions; Eugene Rosenfeld, M.D., consultant for the Presbyterian Board of Missions; and approximately 90% of the private practicing physicians in the five communities of Pikeville, Hazard, Whitesburg, Harlan and Middlesboro.

At each meeting a brief introduction and review of the historical happenings of the last six months was presented by the chairman of the KSMA Hospital Committee; Reverend Corbett spoke as to the purpose and attitudes of the Presbyterian Church; Doctor Rosenfeld presented his group's recommendations; and a discussion and question and answer period followed.

In each of the five meetings, there was grave concern demonstrated by the local physicians. There was a full and free interchange of thought, and the discussions apparently clarified many of the issues that were felt to be present.

The group making the trip returned home greatly impressed with the tremendous opportunities that are going to be open in Eastern Kentucky for the private practice of medicine. It was felt that it should be relatively easy to induce young men to go into this area to practice medicine, particularly with the fine facilities now at their disposal and with the return of normal physician-patient relations.

Council Action: It is recommended by the Council on Medical Education and Hospitals that the report of the Hospital Committee be accepted as presented. The Council would like to take this opportunity to commend Doctor Holloway for the amount of work he has done as Chairman of the Hospital Committee.

Council on Medical Education and Hospitals
James B. Holloway, M.D., Lexington
Walter I. Hume, Jr., M.D., Louisville
Homer B. Martin, M.D., Louisville
Lawrence T. Minish, Jr., M.D., Louisville
J. Murray Kinsman, M.D., Louisville
William R. Willard, M.D., Lexington
Walter S. Coe, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 2

The lengthy report of the Hospital Committee shows that this committee has been a busy one indeed. Our committee wishes to commend Doctor Holloway and his Hospital Committee on the great deal of time they have put into their job this past year, the variety of issues they have been called upon to study, and the manner in which these issues were handled. The committee recommends the acceptance of this section of the report.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Recommendations of the KSMA Board of Trustees

The Board of Trustees reviewed this report on August 8, 1963. The report, including all recommendations, was approved without dissent.

Resolution A

Campbell-Kenton County Medical Society

WHEREAS, the AMA represents the majority of all physicians in the United States and

WHEREAS, the full time Medical School physicians represent an isolated minority which cannot, due to the nature of their daily associations, reflect the thinking of the majority of this country's physicians and

WHEREAS, a high percent of the offices of the AMA are now held by university physicians, Therefore be it

Resolved, that the percent of policy making positions in the AMA which is held by the full time Medical School Physicians be equal to the percentage of this group in the overall membership of the AMA.

Recommendations, Reference Committee No. 2

Resolution A as introduced by the Campbell-Kenton County Medical Society has to do with the ratio of AMA offices held by members in private practice and medical school faculties. After consideration, the committee voted to accept Resolution A, although we must admit that we are very much in the dark on any means of implementation.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and defeated.)

Resolution C

Campbell-Kenton County Medical Society

WHEREAS, teaching centers are well supplied with residents and with medical students so that patient care is no problem and

WHEREAS, interns often have little responsibility in a teaching center, thus depriving them of opportunities to learn and practice and

WHEREAS, private hospitals offer, in many cases, more responsibility plus good teaching and good teaching material and

WHEREAS, the current policy of the AMA continues to shunt even more interns into teaching centers, Therefore be it

Resolved, that the KSMA urges the AMA to adopt a policy encouraging, rather than discouraging interns to serve their internship in private hospitals.

Recommendations, Reference Committee No. 2

Resolution C as introduced by the Campbell-Kenton County Medical Society has as its subject interns serving in private hospitals. The committee voted to accept this resolution.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was seconded. An amendment to the resolution as follows was proposed and seconded.)

WHEREAS, teaching centers are well supplied

with residents and with medical students so that patient care is no problem and

WHEREAS, interns often have little responsibility in a teaching center, thus depriving them of opportunities to learn and practice and

WHEREAS, private hospitals offer, in many cases, more responsibility plus good teaching and good teaching material, Therefore be it

Resolved, that the KSMA urges the AMA to adopt a policy encouraging interns to serve their internship in private hospitals.

(The Resolution as amended was adopted.)

Resolution I

Bell County Medical Society

WHEREAS, the Bell County Medical Society does regard as unethical the conduction of the private practice of medicine by physicians with offices located within the confines of a public, community, tax supported hospital; because it constitutes the exercise of monopoly and creates unfair competition;

WHEREAS, while we do not disapprove in any way the practice of medicine in groups in any given community, we believe the close association of medical groups located in diverse communities, for the purpose of sharing the burdens, responsibilities and benefits of group practice, to be unethical;

WHEREAS, the Bell County Medical Society has previously gone on record through the resolution dated July 31, 1963 and transmitted to the Kentucky State Medical Association's Board of Trustees at the meeting of August, 1963;

WHEREAS, the Bell County Medical Society feels any medical staff in a community hospital should be autonomous, be it

Resolved,

(1) That all doctors now located in the Middlesboro Memorial Hospital with the exception of radiologists, pathologists, and visiting consultants in the various specialties shall show reasonable diligence and progress in finding office space outside the hospital within a reasonable length of time, this time not to exceed three (3) months or by January 1, 1964;

(2) That all patients entering the hospital be given free choice of physician;

(3) That all staff members work on a non-salaried basis;

(4) And that no further physicians shall be given office space within the confines of the Middlesboro Memorial Hospital now or in the future.

Recommendations, Reference Committee No. 2

Resolution I, introduced by the Bell County Medical Society, has as its subject physicians' offices in hospitals. The committee held open hearing on this resolution for approximately one hour. After a great deal of serious deliberation on the many aspects of the resolution as presented in open session of this committee, and using the resolution approved by the KSMA Board of Trustees in April, 1963, (part of which will be found under the report of the Hospital Committee on page 9 of report number 12) as a precedent, the committee voted to accept for adoption and implementation Resolution I.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Resolution M

Laurel County Medical Society

Whereas, the American Medical Association in session assembled took additional recognition of the "importance of the general practitioner as an essential component of American medicine," and

Whereas, once again recognition was taken of the need for "an adequate number of medical school graduates selecting general practice for their medical careers," and

Whereas, the AMA House did resolve to "instruct its Board of Trustees to utilize all facilities at its command to:

A) inform the medical schools of the shortage of general practitioners, and request their cooperation in exposing medical students to general practice by lectures, preceptor programs, and clinical instructors who are practicing general practitioners, and

B) inform the constituent state medical associations of the need to emphasize general practice training and to ask these associations' members to encourage students to go into general practice," now therefore be it

Resolved, that the Kentucky State Medical Association House of Delegates likewise take cognizance of this problem and instruct our Board of Trustees to utilize all facilities at its command with deliberate speed to implement the intent of Resolution 68 passed by the AMA House of Delegates, and further be it

Resolved, that the KSMA Board of Trustees report back to the 1964 House of Delegates what actions have been taken in the State of Kentucky and what progress has been made in solution of this serious problem facing the American Public, namely, the impending critical shortage of general practitioners to serve the public.

Recommendations, Reference Committee No. 2

Resolution M, introduced by the Laurel County Medical Society, has as its subject the implementation of Resolution 68 passed by the American Medical Association House of Delegates, June 19, 1963. The committee voted for acceptance of Resolution M.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 2 as a whole as amended. (The motion was seconded and carried.)

Reference Committee No. 2
Kenneth M. Eblen, M.D., Henderson, Chairman
Guinn S. Cost, M.D., Hopkinsville
Ralph M. Denham, M.D., Louisville
Paul H. Klingenberg, M.D., Covington
John M. Reed, M.D., Mayfield

REFERENCE COMMITTEE NO. 3

E. C. Seeley, M.D., Chairman
Reports on Legislative Activities

Report of the Council on Legislative Activities

Preface

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Legislative Activities is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each committee report.
3. Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.

PART I—NATIONAL AFFAIRS—John C. Quertermous, M.D., Chairman

The Council on Legislative Activities on National Affairs met four times during the last associational year. Some members of the Council attended meetings in behalf of the Association in Los Angeles, Chicago and Atlantic City. One regular meeting was held in Washington, D. C.

Members of the Council and the Committee on Legislative Activities displayed a high degree of interest in the legislative problems of the Association and with the assistance of Bobbie Grogan, Bill Ramsey, the representative from AMA, and President Dave Cox, were able to bring the affairs of this Committee to a level of accomplishment that we feel to be unprecedented.

The Council feels that we have an enviable degree of rapport with the Congressmen in Washington that has been built up by years of enlightened interest in the affairs of our Government. This was highlighted by the most cordial reception we received from the legislators during visits to Capitol Hill before the annual Congressional dinner. The ability of our political body to be decisive or at least clearly instrumental in elections has given more authority to the activities of the Legislative Council.

The liberal factions of Congress are indicating more and more interest in regulating medical problems and during this session have introduced bills intended to regulate everything from the further investigation of Kreboizen (S.J. Res. 101) to providing government medical care to certain ship's officers, crew members and their dependents (S. 969).

The Mental Health bill has drawn much attention in the press and is endorsed in most of its intent by the AMA. The Health Professions Educational Assistance Act of 1963 is opposed by AMA to the extent of the Student Loan provisions involved. The provisions of this act as far as "bricks and mortar" are concerned has been approved by AMA testimony but at the last meeting of AMA the Board of Trustees were asked to reconsider even this provision. Since the Student AMA testified for the loan portion of the bill, our Council thinks the next AMA House of Delegates should pass a resolution requesting a course in medical economics and civics be taught in all medical schools. The "Liberty" amendment has been up for much discussion on the national level. Action was not taken by AMA but they recommended that the members of the profession be made aware of its existence.

It was brought out at AMA meetings that there are instances in which the intent of the Hill-Burton Act was not being carried out in providing grants to Diagnostic Treatment Centers. There are instances in which technically or ethically ineligible groups are applying for Federal funds to build space for closed panel medical groups contrary to the intent of the act.

The King Anderson bill is still lying dormant and is now known as H. B. 3920 and S. 880. It is the thinking by some individuals that no serious effort will be made to pass this bill during this term. However much evidence of "horse trading" with members of the vital House Ways and Means Committee is now taking place preparatory to an all out drive during the presidential campaign in 1964. One offer of a Supreme Court appointment is reliably rumored that would completely undo the solidity of opposition in the Committee and result in an immediate vote on the floor of the House. At such a time the vote may be unfavorable to the welfare of those who practice and depend on the practice of medicine for their physical well being.

IN 1964 WE MAY WELL EXPECT TO LOSE THE FIGHT TO PRESERVE THE PRIVATE PRACTICE OF MEDICINE *OR* TO SEE THE ISSUE LAID ASIDE FOR A DECADE OR SO.

The doctors of Kentucky have an opportunity to fight for their freedom at home with their time and influence and to fight the battle in every other state in the union through contributions to KEMPAC. This neophyte organization has already gained for the Association a great respect among office holders and office seekers and has shown a capacity for objectivity and devotion to the interests of the entire profession that reflects great credit on its founders and Board of Trustees.

We, as individuals, who can deal with people in our own communities, and as members of an association must be informed and aware of developments that may tend to undermine our positions in defending against the socialization of medicine. The administration is busily trying to discredit the effectiveness of the Kerr Mills Program in order to build up public support for this Medicare program. We must be aware that there are Presidential personal favors to depressed areas for those states that will allow their governments to be run from Washington. (An example is the "West Virginia Story").

The Washington Dinner for Congressmen, Senators and Wives and Staff with the Legislative Council, Key Men, Officers and Headquarters Staff was held in April. This, as previously referred to, was thought to be our most successful meeting and best approach to those in Washington. Last year the House of Delegates voted to have the dinner every two years and during odd numbered years when the State Legislature is not in session. Since 1964 is expected to be a critical year for medicine, we think the delegate body should make an exception for next year.

Legislative Council bulletins and special letters were published weekly or according to need for the purpose of informing legislative key men, the Board of Trustees, officers, AMA delegates and specialty group consultants of recent developments. It is hoped that these bulletins be put to the best possible use in informing all doctors of important legislative developments.

At the last meeting of the Legislative Council the following recommendations were proposed to the House of Delegates:

1. Have Congressional dinner early in 1964 honoring our Congressmen and Senators.
2. Have Board of Trustees send a resolution to the AMA House of Delegates requesting that a resolution be passed in form of a recommendation that a course in medical economics and civics be taught in all medical schools.
3. Have Board of Trustees word appropriate resolution to Robert D. Shepard, M.D., commending him for his dedication and leadership as Chairman of State Legislative Affairs and express regrets that he can no longer continue to work in this capacity.

Recommendations, Reference Committee No. 3

Reference Committee No. 3 considered this report which dealt with the activities of the Council and would like to reiterate:

1. A recommendation that the Congressional Dinner be held again early in 1964.

2. A recommendation that the Board of Trustees send a resolution to the AMA House of Delegates requesting that a resolution be passed in the form of a recommendation that a course in medical economics and civics be taught in all medical schools.

3. A recommendation that the Board of Trustees draft an appropriate resolution of appreciation to Robert D. Shepard, M.D., for his services as Chairman of State Affairs.

The Committee voted to approve the foregoing recommendations with the following modification of recommendation No. 2. The Committee is informed that the Jefferson County Medical Society has taken the responsibility for presenting a course in medical economics and civics at the University of Louisville School of Medicine, and the Committee recommends that the House of Delegates request the Fayette County Medical Society to seek the cooperation of the University of Kentucky College of Medicine whereby it might be permitted to take responsibility for presenting this course at that School.

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion was seconded and carried.)

PART II—STATE AFFAIRS—Robert D. Shepard, M.D., Chairman

There has not been a regular session of the State Legislature since our last House of Delegates meeting, consequently, this Council has been less active than usual from the standpoint of State Legislative Affairs. The Governor did call two special sessions this year. The first was to consider re-apportioning the State Senatorial and Representative districts. We did not take an active stand on the re-apportionment bill but did have the approval of the Executive Committee of our Board of Trustees to say that we could support re-districting the representatives by population and the senators by area. The second call was to consider ways for keeping the UMWA Hospitals open. This Council did not receive any instructions from the Board of Trustees on this legislation, therefore, we were inactive.

The Executive Committee of the Trustees gave our Council a directive to arrange a meeting of the Governor candidates, prior to the Primary Election, with members of the Council, the Board of Trustees and members of KEMPAC. Since this is one of the main purposes of KEMPAC and since such action would by-pass this organization, it was agreed that this could be detrimental to its proper function. Therefore, the Executive Committee was asked to reconsider, and all contacts with candidates, now and in the future, be transferred to KEMPAC for implementation. It is considered the duty of the Legislative Council to work with officials after they have been elected.

Resolution "H" of the 1962 House of Delegates requested the Board of Trustees to proceed with a vigorous public education program in regard to cults. When this matter was passed to this Council from the Board, three ways of attacking the problem were considered as follows: legislative, judicial and educating the public. The latter was selected and we have and are now in the process of working on this approach. When the Board of Trustees were presented the plan of publishing ten different articles on cultism in a large number of newspapers and were told the cost would be in the neighborhood of $10,000.00, this matter was delayed for future action. The Council has asked our attorney, Mr. E. Gaines Davis, to condense the ten articles into an informative pamphlet so it can be printed in large quantities for distribution in hospitals, drug stores, dentist and physician offices. This pamphlet when complete will be reviewed by the Council and then forwarded to the Board of Trustees for final approval.

In case legislation is introduced against cults or by cults, a survey has been conducted by this Council among our KSMA members in order to obtain positive information on cultism. About half of our members returned the forms and almost 50% of those answering said they had some positive information. This has been filed as a valuable source of obtaining more detailed information concerning their activities when it is deemed advisable.

The idea of having an emergency aid station in Frankfort manned by two physicians each day during the 1964 Legislative Session has been considered by the Council and Trustees. It is generally agreed that this would be a worthy public service and should be undertaken by our members in event resolutions are introduced by the legislators requesting this service.

As you may recall, a Good Samaritan Act (Emergency Care Legislation) was drafted to be presented at the last session of the State Legislature. This particular bill, when reviewed by the Legislative Research, was found to be (in part) unconstitutional in the State of Kentucky. A new bill was prepared by Mr. Gaines Davis which, in essence, would permit a doctor to stop, render first aid and then go on his own way. This bill has been recommended to the Board of Trustees for implementation in 1964.

The naming of sub-district key men and revision of the Key Man System was delayed until after the primary. A list of these men has been presented to the Board of Trustees for their approval.

The Council for State Affairs wishes to propose the following resolution for consideration and adoption by the House of Delegates:

"Whereas, Chambers of Commerce are potentially one of the strong forces in existence to perpetuate and refine our free-enterprise system, and

"Whereas, most Chambers of Commerce are dedicated to the improvement of the general welfare of our communities, and

"Whereas, Chambers of Commerce depend upon and need the talents and resources of the businessmen and professional men dedicated to the improvement of the free-enterprise system, be it therefore

"RESOLVED, that the Trustees recommend that each county medical society endorse and urge its members to support the State Chamber of Commerce, and be it further

"RESOLVED, that the Trustees recommend that each physician affiliate himself with his local Chamber of Commerce to work for the accomplishment of mutual objectives."

In closing, your State Chairman would like to take this opportunity to thank Doctor Quertermous and the other members of the Legislative Council for the wonderful opportunity they have offered me these past few years. It is with deep regret that I have been forced to resign as a member of this Council. I would also like to express my sincere gratitude to Mr. Joe Sanford, Mr. Bobbie Grogan, his wonderful secretary, Mrs. Florene Johnson, and the other KSMA staff for the cooperation shown me by each and every one.

I would make one final request. In my opinion the new chairman for State Affairs should be allotted a small expense account; namely, his expenses to the Washington Dinner and mileage during the session of the State Legislature. He will spend many hours driving to and from Frankfort.

Council on Legislative Activities
Branham B. Baughman, M.D., Frankfort
Hoyt D. Gardner, M.D., Louisville
Daryl P. Harvey, M.D., Glasgow
Thomas Leonard, M.D., Frankfort
F. R. Scroggin, M.D., Dry Ridge
John C. Quertermous, M.D., Murray,
Chairman—National Affairs
Robert D. Shepard, M.D., Lexington,

Recommendations, Reference Committee No. 3

Reference Committee No. 3 considered this report which dealt with the activities of the Council with respect to State Affairs, and, in addition to the informational content, considered particularly the following points:

1. The Council feels that the establishment of an emergency aid station in the Capitol at Frankfort manned by voluntary physicians would be a worthy public service and should be undertaken in the event

resolutions are introduced by legislators requesting this service.

2. A resolution that the trustees recommend that each county medical society endorse and urge its members to support the State Chamber of Commerce and that the trustees recommend that each physician affiliate himself with his local Chamber of Commerce to work for the accomplishments of mutual objectives.

3. The Council recommended that the Chairman for State Affairs should be allotted a small expense account—namely his expense to the Washington Dinner and mileage to and from Frankfort during the Session of the State Legislature.

The Committee voted to approve this report and all of its recommendations in its entirety. The Reference Committee would further like to commend Doctor Quertermous and Doctor Shepard and their Council on the diligence and devotion to their duties as members of this Council.

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion seconded; carried.)

Recommendations of the KSMA Board of Trustees

The Board of Trustees reviewed this report on August 8, 1963. The report, including all recommendations, was approved without dissent.

Report To The Legislative Council

This is a report of attendance and activities at the national medical legislative conference held in the Congress Hotel, Chicago, Illinois, April 20-22, 1963. As a representative of the Kentucky State Medical Association, I attended the sessions of the conference entitled the National Medical Legislative Conference. This was a conference attended by approximately 500 representatives of the various medical societies in the United States. It was sponsored by the American Medical Association through the Council on Legislative Activities. The general staff of the American Medical Association participated in the conference, as well as physician members who made up the Council on Legislative Activities. The President of the American Medical Association, Doctor George N. Fister, presented the welcoming address in the initial session on the first day, Saturday morning. He was concerned with analysis of the House of Representatives' bill 3920. This was discussed from its legal and financial points of view. At a luncheon that day, the Honorable Gerald Ford, of Grand Rapids, Michigan, representative to the U. S. Congress, discussed the role of the conservative in the United States today.

The afternoon session was dedicated to a description of the operation home town program and its implementation in other areas throughout the country.

The third session, held the next morning, discussed the relationship of the organized churches to national medical legislation. The remainder of the morning program was devoted to an analysis of the Kerr-Mills bill in action throughout the United States. A most stimulating address by President-Elect Edward R. Annis closed the program.

An afternoon session was attended, sponsored by the National Speakers' Bureau. It was concerned with methods and techniques of approaching lay audiences. After attending this session, I concluded that the American Medical Association is indeed fortunate to have gifted leaders at this time. I was impressed with the quality and devotion of the lay staff of the AMA headquarters. With the information and enthusiasm which we gained from this meeting, we have established the Operation Home Town program in Fayette County, Kentucky.

David B. Stevens, M.D., Lexington
Chairman Committee on Legislative
and Public Health
Fayette County Medical Society

Recommendations, Reference Committee No. 3

Reference Committee No. 3 considered the report of David B. Stevens, M.D., Lexington, who attended the National Legislative Conference. The Committee voted to adopt his report in its entirety and commend Doctor Stevens upon his report and for his attendance at this Conference.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Resolution G
Campbell-Kenton County Medical Society

WHEREAS, the use of X-ray and fluoroscopy for diagnosis and treatment of patients is becoming more complex, and

WHEREAS, radiation exposure need be closely controlled in view of the growing problem of fall-out radiation, Therefore be it

Resolved, that the KSMA urge that the use of x-ray and fluoroscopic machines be limited by law, to physicians and surgeons, dentists, veterinarians, osteopaths and closely controlled industrial users.

Recommendations, Reference Committee No. 3

Reference Committee No. 3 considered the resolution that the KSMA urge that the use of X-Ray and fluoroscopic machines be limited by law to physicians, surgeons, dentists, veterinarians, osteopaths and closely controlled industrial users.

It was the judgment of the Committee that this constitutes only a small segment of a larger overall problem which is now being dealt with by the Council on Legislative Activities and should not be the subject of special legislation. The Committee, therefore, voted to disapprove the implementation of this resolution.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded. It was then moved and seconded that the following amendment be inserted in the Reference Committee Report: "Reference Committee No. 3 considered the resolution that the KSMA urge that the use of X-Ray and fluoroscopic machines and all radio-active materials for medical use be limited by law to physicians, surgeons, dentists, veterinarians, osteopaths, and closely controlled industrial users . . ."

The question on the amendment was called for and it was defeated. The House then voted on the motion of the reference committee and it carried.

Mr. Speaker, I move the adoption of this report as a whole. (The motion was seconded; carried.)

Reference Committee No. 3
E. C. Seeley, M.D., London, Chairman
James W. Miller, M.D., Greensburg
Bernard J. Schoo, M.D., Louisville
Frederick R. Scroggin, M.D., Dry Ridge
James G. Sills, M.D., Hardinsburg

REFERENCE COMMITTEE NO. 4

Paul J. Parks, M.D., Chairman
Reports on Public Service and Allied Professions

Report of the President

(Page 2, Paragraph 3)

The KSMA Council on Communications and Public Service was asked by the 1962 House of Delegates to make recommendations to the 1963 session of the House on a system of mandatory indoctrination of new KSMA members. (The 1962 House did

not feel a voluntary plan was adequate.) Gentlemen, if you were to serve as an officer in this organization and you really wanted to see it fulfill its true potential for service to the public and the profession, you would certainly concur in the need for more and more young men to become knowledgeable and proficient in the operation of the association's program and policies. In order to supply this need, the Council will recommend what I believe to be a carefully planned and very practical mandatory indoctrination program. Medical organizations we belong to require us to meet certain standards. We sincerely hope that you will support in the interest of building a more useful profession, the Council's recommendation.

Recommendations, Reference Committee No. 4

Reference Committee No. 4 recommends the adoption of the President's Report Page 2, Paragraph 3, having to deal with a system of mandatory indoctrination of new KSMA members on a state-wide level. It seemed to the Committee that adequate study had been done by a sub-committee regarding doing this on a voluntary basis and that after a poor trial of that method, this more efficient method should be tried.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Council on Communications and Public Service

Preface

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the Bylaws, which reads in part:

> ". . . . Each standing committee and council shall report annually at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . . ."

The material in this report of the Council on Communications and Public Service is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each committee report.
3. Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.

* * * * *

The Council on Communications and Public Service has held two meetings during this associational year, January 17 and July 11, 1963.

There are eight committees serving under the Council on Communications and Public Service. They are Diabetes, Emergency Medical Services, School Health, Public Health, Senior Day, Highway Safety, Advisory to Woman's Auxiliary, and the Rural Health Committee.

At its first meeting, the Council heard the reports of the activities and plans of the committees serving under the Council. At the request of the Council, a number of items appeared in "Newscaps" and the KSMA Journal which were felt to be in the interest of KSMA members.

We have continued our effort to place exhibits of a health nature which would be interesting and informative at a number of meetings. Exhibits this year have been shown at the Annual Meetings of the Kentucky Education Association, Kentucky School Boards, KSMA, and in the Health-O-Drama Section at the Kentucky State Fair.

The Council is pleased to inform the membership:

1. That exhibits have been approved for the 1964 meetings of KEA and the Kentucky School Boards.
2. That KSMA is continuing its membership in the Kentucky Press Association.
3. That with the cooperation of the American Medical Association, thousands of pamphlets directed against Socialized Medicine were distributed by Jaycees at the Tri-State Fair in Middlesboro during June of this year.
4. That Medical Career Kits are being sent to all city and county school superintendents in Kentucky and are being made available for all high schools.

The Council recommends that two of KSMA's publications, namely "Newscaps" and the "Secretary's Letter," be combined into one single publication which would be distributed to the KSMA members as the need is indicated rather than on any specific date and that the official name of this publication be determined by the Board of Trustees.

Last year the Council recommended that an Indoctrination Program be initiated so that all members may have an opportunity to be indoctrinated to the benefits of membership in organized medicine. This recommendation was returned to the Council in that it was felt that the program could be improved by making the new-membership indoctrination compulsory at a state level. This year the Council appointed a sub-committee to study inquiries that were sent to all state medical associations and selected county societies requesting information on Indoctrination Programs. Having heard the report of this sub-committee, the Council recommends to the House of Delegates through the Board of Trustees, that a KSMA Indoctrination Program be initiated, that attendance be mandatory for all new KSMA members, and that new members have a period of two years to complete their indoctrination by attending one of a number of scheduled programs. The Council further recommends that the KSMA Bylaws be amended to accomplish a mandatory new-member Indoctrination Course on a state level.

The following reports of the committees serving under the Council are herewith submitted:

Rural Health Committee, James Salato, M.D., Columbia, Chairman

The Rural Health Committee has held two meetings since the last session of the House of Delegates. A large portion of the time dealt with planning the 1962 Rural Health Conference, which was held at Cumberland Falls State Park, October 25, 1962, and planning the 1963 Conference to be held October 24, at Jenny Wiley State Park near Prestonsburg, Kentucky.

We are of the opinion that the Cumberland Falls Conference was the best held in recent years. The theme was "Community Health Service—A Key to Area Development." The Program was specifically planned for approximately twenty-four counties in the Falls area. Most of the program participants were from that area. After a morning session of profile reports by physicians, dentists, nurses, pharmacists, health department personnel, and hospital employees, the afternoon session dealt with the specifics on how to cope with the existing problems and to pinpoint needs and opportunities for town, county, and area council programs. To accomplish this, the audience was divided into three groups.

Our Committee was well pleased with the 185 people who attended and particularly so since the audience represented those individuals we try to reach with our Rural Health Conference.

Because of the excellent program and the good attendance, the Program Committee for the 1963 Conference has decided to have practically the same

program, but in a different area so there will not be an overlapping of counties.

Members of the Rural Health Committee have been active in writing articles for the Kentucky Farm Bureau News. This publication is circulated among approximately 80,000 farm families and from all reports, these articles have been well received.

The National AMA Safety Conference was held in Chicago on April 5-6, 1963. Although no member of the Committee attended this meeting, we did send our secretary, Mr. Grogan. The Kentucky Farm Bureau, a member of the Kentucky Rural Health Council, sent their Public Relations Director, Mr. William Padon. Both reported the Conference was an excellent one and commented it pertained mainly to how farm accidents happen and what causes them to happen. It was their opinion that this subject would make for a good program at one of our future conferences.

Mitchel B. Denham, M.D., has been representing the Rural Health Committee on the Kentucky Agriculture Council. Doctor Denham states that this Council meets four times each year, and he is recommending that the Rural Health Committee Chairman and Mr. Grogan also serve with him on this Council.

In closing this report, our Committee extends a sincere invitation for doctors throughout the State to attend the Rural Health Conference at Jenny Wiley State Park on October 24, and particularly to all doctors in eastern Kentucky.

Council Action: The Council recommends that the report of the Rural Health Committee be accepted as presented.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption of the report of the Rural Health Committee as presented. (Motion seconded and carried.)

Diabetes Committee, Robert S. Tillett, M.D., Louisville, Chairman

The Diabetes Committee of the Kentucky State Medical Society met Wednesday, June 12, 1963. Although a quorum of members was not present, guests at the meeting included David M. Cox, M.D., KSMA President, and Mr. Eldon Kronewitter, for the Kentucky State Board of Health, Frankfort, Kentucky.

Results of previous diabetic drives were reviewed and it was concluded that the follow up reporting on the detection drive programs seems to be the weakest link in the chain. The members of the committee felt that this portion of the program might be improved by the county chairmen requesting the name of the patient and his physician when the urine tests are collected. Also in reporting the results of the drive, each county chairman is requested to list the names of the patient and physician on all positive tests, so that follow up can be obtained on the screening positives.

The committee was also informed that space would probably be available for conducting diabetes testing at the Health-O-Drama Exhibit at the Kentucky State Fair in September of 1963. The committee agreed that participation in the Health-O-Drama would be highly desirable in conjunction with organizations listed below for the purpose of giving free diabetes detection tests. The organizations include the Kentucky Diabetes Association, the Kentucky State Medical Association Committee on Diabetes, the Jefferson County Medical Society Committee on Diabetes, the Jefferson County Lay Society of the Kentucky State Diabetes Association, the Kentucky State Department of Health, the Jefferson County Health Department, and the Medical Technician Society. Attempts to carry out this program will be made if participation by these groups can be forthcoming.

Council Action: The Council recommends that the report of the Diabetes Committee be accepted as presented.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption of the report of the Diabetes Committee as presented. (Motion seconded; carried.)

Emergency Medical Services Committee, William T. Rumage, Jr., M.D., Louisville, Chairman

The Emergency Medical Services Committee met at frequent intervals during the past year. The following list of projects is not in order of importance.

1) The Executive Assistant contacted all of the counties to ascertain if they had a disaster planning committee and who the chairman of that committee was. It has been found that twenty-five counties have disaster planning committees, and correspondence has been maintained with these county committees.

2) The Committee and the Executive Assistant served as consultants in establishing a disaster plan for Fayette County.

3) The Committee reviewed a check list submitted for approval by the American Hospital Association and the American Medical Association to assist local hospitals in making their disaster plans.

4) The Committee and Executive Assistant have participated in plans of the State Task Force for Health Resources Committee. A list of all of the doctors in Kentucky with their special interest has been filed with this committee.

5) The Committee has participated in presenting the Medical Self-Help Training Program to the Boone County and Marion County Medical Societies and cooperated in securing a Self-Help Training Kit for instructional purposes at the University of Louisville School of Medicine. Fifteen hundred one (1501) persons have been reported to the State Department of Health as having completed the Medical Self-Help Training Course in Kentucky.

6) This Committee of the Kentucky State Medical Association and its Executives Assistant have met with the disaster planning committee of the Kentucky Hospital Association and its Executive Secretary for further understanding of their mutual problems.

7) A Civil Defense Emergency Hospital was demonstrated at the Columbia Auditorium during the 1962 meeting of the KSMA and was also demonstrated in Nelson County. It is contemplated that the hospital will be demonstrated in Fayette County and to the Kentucky Hospital Association and the Kentucky Education Association next year.

The Committee and the Executive Assistant have been consulted about the establishment of a Civil Defense Emergency Hospital in Jefferson County and in Meade County.

8) The first aid list as prepared by the Committee is continuously distributed to the public on request. The Kentucky Pharmaceutical Association has adopted the list and has made it available in their pharmacies across the state. The list has been sent to the county medical societies and through the office of civil defense of the government has been sent to all the county civil defense directors. Newspaper stories have been published across the state drawing attention to the availability of this list.

9) The Committee has agreed in principle to the appointment of a medical reserve officer of the air force to serve as a liaison between the air force and the Committee of the Kentucky State Medical Association.

10) Harmonious relationships which have been established with the Flying Physicians Association have been continued in the past year.

11) The Committee and the Executive Assistant are now in the process of writing an issue of the Journal of KSMA on disaster planning. Tentative date of publication is January, 1964.

12) It is the recommendation of the Committee that funds be made available to pay travel and hotel

expenses of a member of this Committee to attend two meetings per year in disaster planning. This is the most worthwhile way in which new people can be brought into this Committee with a background in disaster planning and be available to pass on this information to the other members of the Kentucky State Medical Association.

13) It is recommended that this Committee be consulted by the Legislative Committee about legislation which may be necessary to protect doctors who teach and practice first aid. This legislation is ordinarily referred to as "Good Samaritan Legislation."

Council Action: The Council recommends that the report of the Emergency Medical Services Committee be accepted as presented.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption of the Report of the Committee on Emergency Medical Services with the exception of Item 12, Page 7, which deals with the pay travel and hotel expenses of a member of this Committee to attend two meetings per year in disaster planning. This Committee feels that in view of the financial condition of the Association and the fact that this will be setting a precedent for Committee expenses, that it should not be recommended at this time. (Motion seconded; carried.)

School Health Committee, R. E. Davis, M.D., Central City, Chairman

The major effort of the School Health Committee during the preceding year has been to conduct a series of six athletic injury prevention conferences under the sanction and in co-operation with the Kentucky High School Athletic Association. These meetings were held at the University of Kentucky Center in Cumberland, Kentucky; Western State College in Bowling Green, University of Louisville at Louisville; Morehead State College of Morehead; Murray State College at Murray; and Eastern State College at Richmond.

A team of physicians was selected by the School Health Committee to present these programs to coaches and students interested in becoming coaches. Dentists were present and were a part of the program at four of these colleges, namely Western, U of L, Murray, and Eastern. The chairman of this committee is very grateful for the assistance given by the physicians, the KHSAA, and the Headquarters Staff of KSMA in carrying out these programs. It is felt that a significant number of people were reached under this program, and that this was the beginning of a worthwhile effort.

The first scheduled meeting of this committee was December 27, 1962. During this meeting the most significant factor was that the report on the Resolution on Physical Education was presented to the committee as having been passed upon by the House of Delegates at the prior Annual Meeting. A copy of this resolution was sent to Wendell P. Butler, Superintendent of Public Instruction. It is the hope of the entire committee that this will receive some action by the Department of Education.

It was noted that there was a good attendance of the School Health Committee's exhibit at the prior Annual Meeting, and it was further noted that there was a large number of physicians that registered. The second meeting of the School Health Committee was held on April 4, 1963, and was well attended. As a guest we had Mr. J. B. Mansfield of the Kentucky High School Athletic Association, who discussed the Athletic Injury Prevention Conference that was held during the fall of 1962. A general discussion was held concerning these conferences with an idea as to planning the conferences for the coming year. It was suggested by Mr. Mansfield that we would be able to secure a captive audience for these conferences by holding them in conjunction with the KHSAA Football Rules Clinics and Basketball Clinics. KHSAA expressed itself through Mr. Mansfield as being strongly in favor of continued clinics; this feeling was shared by the members of the School Health Committee. The members of the committee also agreed that these sessions would be more interesting if presented by physicians who live and practice in the areas in which these conferences are to be held.

The final meeting during this year was held on June 20, 1963. It was brought out by William Haley, M.D., Paducah, that the school system of Paducah is in the process of developing a vigorous program of physical education in their school system, and that this excellent program is rewarded by a series of distinctive patches denoting various grades of achievement. The members of this committee expressed great hope that this was the beginning of an epidemic. It was decided that three programs would be held on the subject of Athletic Injury Prevention, and presented to coaches on August 26 at Newport, and presented by the Campbell-Kenton County Medical Society; and the program on August 28 at Louisville to be conducted by the members of the Jefferson County Medical Society. It was further decided to have a third conference on Athletic Injury Prevention in western Kentucky, probably at Mayfield, to be presented by Doctor Haley and western Kentucky physicians.

The Chairman of the School Health Committee wishes to acknowledge the invaluable assistance given him by the members of his committee, and the members of the KSMA Staff. Very little could have been accomplished without their assistance.

Council Action: The Council recommends that the report of the School Health Committee be accepted as presented.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption of the Report of the School Health Committee as presented. (Motion seconded and carried.)

Highway Safety Committee, Arthur H. Keeney, M.D., Louisville, Chairman

This second annual report continues an accounting of the activities of this committee subsequent to the first report submitted July 5, 1962. During this time there have been significant accomplishments growing out of the preliminary work and preparation which the committee pursued from its creation, April 6, 1961. Activities of the committee have received favorable recognition, not only as news items in the various media, but editorially in local and state-wide papers. There has also been distinct and favorable recognition of the committee program through regional and national organizations concerned in the same field, by actions of endorsement at national committee level and by editorial and news comments in nation-wide media. This has been encouraging to the committee which often felt it was laboring uphill in darkness.

Specific activities in the past year have been:

1. The "Kentucky-Cornell" Automotive Crash Injury Research Program went into full scale operation, August 1, 1962, and as of August 1, 1963, will begin its third phase in the third pre-selected geographic area of Kentucky. Cooperation with hospitals, physicians, and the Department of Health, Division of Accident Control, has been gratifying both to this committee and to the staff of Cornell. It is anticipated that this program will continue its sampling of multiple-passenger vehicle injury or fatality-producing wrecks throughout the projected three-year period.

2. On request of the Highway Safety Committee and invitation of the Committee on Scientific Exhibits, the Department of Public Safety of the commonwealth again prepared and installed an excellent

exhibit on seatbelts and highway safety at the Annual KSMA Meeting, in Columbia Auditorium, September, 1962. At the same meeting, the Irving Airchute Company, of Lexington, also consigned seatbelts which were again sold by the ladies of the Jefferson County Auxiliary at cost during the meeting. Letters of thanks went to each of the auxiliary wives who manned this booth (Mrs. A. Evan Overstreet, Mrs. Jerry M. Shaw, Mrs. Glenn Barton, Mrs. Walter I. Hume, Jr., Mrs. Robert Tillett, and Mrs. Carroll H. Robie). There was good newspaper coverage, both by pictures and stories concerning these activities at the state meeting.

3. The Highway Safety Committee prepared the "Kentucky Resolution on Automobile Manufacturers' Safety Compact," a copy of which is available in the KSMA Headquarters Office. This was introduced by Colonel David Espie, Chief of the Kentucky State Police, at the meeting of the American Association of Motor Vehicle Administrators, in Las Vegas, Nevada, October, 1962. This resolution calling on manufacturers immediately to compact in the definition and inclusion of standard safety equipment on all automobile models was passed by the Association. Though this was a clear and strong resolution, it has not received implementation from the American Association of Motor Vehicle Administrators, as did House Resolution No. 43, passed in the Commonwealth of Kentucky General Assembly, 1962. This may be related to the fact that the annual meetings, banquets, etc., of the American Association are largely financed by the motor vehicle industry. This resolution, however, was subsequently endorsed at the March 9 meeting of the AMA Committee on Medical Aspects of Automotive Safety in Pittsburgh.

4. Planning meeting with the Administrative Assistant of the Commissioner of Safety, November 8, 1962, for finalizing program of driver limitation as a medical responsibility.

5. Presentation of Highway Safety Program to the joint meeting of Shelby, Oldham, and Henry County physicians, at Simpsonville, Kentucky, November 15, 1962.

6. Meeting with Safety Director Wallace R. Hoaglund, of the City of Louisville, in an effort to secure uniform seatbelt usage by the Louisville Police Department, as is currently done by the state and county police. Formal announcement of installation of such belting in city police cars was announced by the Director of Safety, on December 14, although obligatory use instructions were not issued.

7. Formal meeting of complete Highway Safety Committee and guests from the Department of Health and Department of Public Safety, January 3, 1963, at Headquarters Office, for refinement of program in medical aspects of driver limitation.

8. Presentation of Kentucky program and its ramifications to New Orleans Academy of Ophthalmology, Annual Meeting on Trauma, February 12, 13, and 14, 1963. These three papers will be published in volume form by C. V. Mosby, Company.

9. Meeting of Highway Safety Committee, President of KSMA, State Commissioner of Health, Administrator of Department of Public Safety, and representatives of U. S. Public Health Service for formalization of Kentucky Program in medical aspects of driver limitation. Complete unanimity was secured at this meeting on the areas of medical limitation in driving and the methods by which this program would be implemented under existing Kentucky Revised Statutes. A prospectus of this program is available in the KSMA Headquarters Office.

10. Acknowledgement of the program of this committee was made by the AMA Committee on Medical Aspects of Automotive Safety by requesting the chairman of this committee to serve on the corresponding AMA Committee. This was done with the chairman attending the first meeting in Pittsburgh, March 9, 1963. At this time the AMA committee generally endorsed the Kentucky program of medical aspects of driver limitation and requested that it be prepared as a basis for an AMA White Paper, stating the position of the AMA on medical aspects of driver limitation. This is currently in progress of formalizing by the AMA committee and will be presented at the next committee meeting in Chicago, on July 13, 1963.

At the same meeting the AMA committee also endorsed the Kentucky Resolution on Motor Vehicle Manufacturers Compacting, which has not been implemented by the American Association of Motor Vehicle Administrators.

11. Full-day meeting with technical staff members of Corning Glass Works, Corning, New York, March 14, 1963, concerning development of truly satisfactory safety automotive glazing in an effort to end the controversy now existing between laminated glass manufacturers and heat-tempered glass manufacturers. It appears that the Corning "Chemcor" process offers excellent protection to motor vehicle occupants but is not yet adequately tested and is not yet programmed for distribution.

12. All day conference at Cornell Automotive Crash Injury Research Offices, Buffalo, New York, March 15, 1963, for review of Kentucky-Cornell Program and planned implementation of further steps.

13. Presentation of KSMA program to Daviess County Medical Society in Owensboro, March 26, 1963, with Commissioner Glen Lovern and Chief of Police Bidwell, of Owensboro, as guests in attendance.

The committee wishes to acknowledge the generous coverage by news and complimentary editorials, as appeared in the Louisville Times, February 23, 1963; the Lexington Herald, February 25, 1963; Owensboro Radio WOMI, May 16, 1963; The Kentucky Journal of Highway Traffic, April 1963 (Page 10); The Louisville Automobile Club Bulletin, May-June 1963 (Page 3); Medical Tribune, May 17, 1963; Medical World News, April 12, 1963 (Page 17); The Sciences (published by New York Academy of Sciences), May 1, 1963 (Page 11); and others whose encouragement has not been specifically brought to the attention of the committee.

The committee has now presented certificates for 100% seatbelt usage to the Highland Lions Club of Louisville (September 6, 1962), Sears Roebuck and Company Service Station Department (September 13, 1963), Louisville Taxicab and Transfer Company, the B-Line Cab Company, of Louisville; the Kentucky Regional Sports Car Club of America (December 18, 1962), and Certificate No. 6, most recently, to the Jefferson County Police (May 20, 1963).

Future plans for this year include a scientific exhibit on shoulder harness and infant's restraining devices at the KSMA Meeting in September. The activation of the Kentucky program on medical limitation of driving ability and further pursuit of the concept that automobiles should be rendered less injurious by better design.

The Highway Safety Committee, conjointly with the Jefferson County Medical Society, sponsored the visit of Horace E. Campbell, M.D., of Denver, Colorado, to Louisville, Frankfort, and Lexington, on May 20 and 21, 1963. Doctor Campbell is a nationally distinguished expert on automotive safety and was extremely well received at each place where he spoke, receiving good news media coverage in the papers and on television. He also addressed the Department of Surgery at both of the Kentucky schools of medicine.

The Committee requests:

1. Approval of the program to date by the Council on Communications and Public Service.

2. Endorsement by the Board of Trustees of the general direction in which the committee is moving

and authorization to continue along these general lines.

3. Support of an annual financial allotment to this committee of $300 to cover cost of certificates and incidental expenses paid from the secretary's office at the KSMA Headquarters.

The committee will be pleased to receive any additional suggestions from the Council, Trustees, or members of the KSMA.

Council Action: The Council recommends that the report of the Highway Safety Committee be accepted as presented.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption of the Report of the Highway Safety Committee with the exception of Item 3, Page 13, which deals with an allotment of $300 to cover cost of certificates and incidental expenses now being paid from the Secretary's Office, at KSMA Headquarters. It is the feeling of this Committee that the sum of $150 should be sufficient to cover this expense, and this change is recommended.

Mr. Speaker, I move the adoption and implementation of this section as presented. (Motion seconded; carried.)

Public Health Committee, Delmas M. Clardy, M.D., Hopkinsville, Chairman

Since the last report of this Committee, more than half the population of Kentucky has been immunized against the three types of anterior poliomyelitis. The Committee is grateful that there was such enthusiasm among the physicians to carry out this state-wide program. The help and cooperation of the many and various groups and individuals was superb. Letters were written to the various county societies thanking them for their fine work, and urging the secretaries to thank everyone else, especially the representatives of the drug houses who manufactured the vaccines. A letter to the companies commending these people by name, by the county secretaries is in order, and might result in financial benefit to them.

The polio campaign was successful to the point that it overshadowed the annual Immunization Week, which was during the first full week of May, the results of which are difficult to evaluate. With the compulsory immunization law in effect, it may be wise to abandon Immunization Week, as it seems the results are not in proportion to the efforts. Comments from the membership to the Committee would be appreciated.

Fluoridation of public water supplies is progressing slowly, but surely. The State Department of Health is aggressive on this subject, and as a point approval, fluoridation is being included for requirement. The results of fluoridation are no longer debatable. Chiropractors, food fadists, and a few other cultist groups are the only ones to oppose this most important program. Their opposition is especially effective when there is a public referendum.

The death rate from carcinoma of the cervix uteri has not yet been affected by our efforts through the "Pap" smear. This may mean that we should push this program to a great degree.

Venereal disease, as reported last year, is becoming a problem. Its control is necessary, and the suggestions made last year are still good. There has been some complaint from the Department of Health about refusal on the part of some to report cases. We are assured that scientific and proper methods of investigation are carried out, without embarrassment to anyone, when a case is reported. The Committee feels that reporting of cases is necessary if effective control is to be established, and we urge each member of this Association to do his part.

The Committee discussed at length the subject of "Tobacco & Health," fully acknowledging the aspects of the economy of a great section of the nation, as well as alienation of the goodwill of our friends, the farmers, and the manufacturers of tobacco products. The death rate from bronchogenic carcinoma continues to mount and the evidence of its precipitating cause continues to increase. There is little doubt in the scientific minds of the world about the conclusions drawn from this overwhelming evidence. Organized medicine cannot, in good faith, continue to dodge this issue very much longer. This Committee is making no recommendations at this time because of the present studies of "Tobacco & Health" being carried out by the Surgeon General of the United States Public Health Service. The American Medical Association stopped its study for the same reason.

At its meeting this year, this Committee had no specific recommendations to be acted upon by the House of Delegates.

Council Action: The Council recommends that the report of the Public Health Committee be accepted as presented.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption of the Report of the Public Health Committee, as presented. (Motion seconded and carried.)

Advisory Committee to the Woman's Auxiliary, Coleman C. Johnston, M.D., Lexington, Chairman

The Advisory Committee to the Woman's Auxiliary held no formal meetings this year, and a written report was not submitted.

Council Action: The Council recommends that the report of the Advisory Committee to the Woman's Auxiliary be accepted.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption of the Report of the Advisory Committee to the Woman's Auxiliary as presented. (Motion seconded and carried.)

Senior Day Committee, Donald Chatham, M.D., Shelbyville, Chairman

The Senior Day Program was held March 18, 1963. David M. Cox, M.D., President, KSMA, spoke to the group at the morning session in Rankin Amphitheater.

The afternoon sessions were held in the Medical Arts Building auditorium with thirteen topics discussed briefly. These concerned matters thought to be most helpful to the graduating seniors. The students were guests of the Jefferson County Medical Society for the social and dinner hour. James Comstock, editor of The West Virginia Hillbilly was the after-dinner speaker.

Evaluation of the students' comments on the total program revealed a gratifying result.

On behalf of the Council on Communications and Public Service and the KSMA, I express gratitude to the Jefferson County Medical Society, its President, Louis Foltz, M.D., Harry Lehman, Executive Secretary of the Jefferson County Medical Society, the members of the Senior Day Committee, Bob Cox of the KSMA Staff, and especially to Wyatt Norvell, M.D., who on a few hours notice presided as Chairman for the day because of illness of the original chairman.

Council Action: The Council recommends that the report of the Senior Day Committee be accepted as presented.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption of the Report of the Senior Day Committee as presented. (Motion seconded; carried.)

As chairman, I would like to express my appreciation to all of those who served on the Council and to commend the committees that have served under

the Council for their work during the Associational year.

The Council on Communications and Public Services is charged with the responsibility of supervising and directing all Associational activities in the field of Public Relations and Services.

Council on Communications and Public Service
Donald Chatham, M.D., Shelbyville
R. E. Davis, M.D., Central City
Arthur H. Keeney, M.D., Louisville
William T. Rumage, Jr., M.D., Louisville
James Salato, M.D., Columbia
Robert S. Tillett, M.D., Louisville
N. Lewis Bosworth, M.D., Lexington, Chairman

Recommendations, KSMA Board of Trustees

The Board of Trustees reviewed this report on August 8, 1963. The report, including all recommendations, was approved without dissent.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption and implementation of the Report of the Council on Communications and Public Service as amended. (Motion seconded and carried.)

Report of the Council on Allied Professions and Related Groups

Preface

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the Bylaws, which reads in part:

". . . . Each standing committee and council shall report annually at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . . ."

The material in this report of the Council on Allied Professions and Related Groups is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each committee report.
3. Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.

During the associational year, the Council on Allied Professions and Related Groups has held one meeting on July 17, 1963, for the purpose of hearing the reports from the various committees assigned to this Council, which are: Dental-Nurse-Pharmacy, Physical Medicine and Rehabilitation, Infant and Maternal Mortality, Tuberculosis, Blood Banks, and the Industrial Medicine Committee.

The Council on Allied Professions and Related Groups recommends that the Board of Trustees appoint all committees and councils for the new year prior to the KSMA Annual Meeting of the current year. This would enable the committees to meet formally and/or informally during the Annual Meeting to plan the activities for the coming year.

Submitted below are the reports of the committees serving under this Council:

Dental-Nurse-Pharmacy Committee, Lloyd G. Yopp, M.D., Louisville, Chairman

No formal meeting of the Dental-Nurse-Pharmacy Committee was held during the past year. A number of pieces of literature relevant to the committee were sent to the chairman for his review. A routine report was sent in by the chairman answering a questionnaire sent by the AMA Committee on Nursing.

Council Action: The Council recommends that the report of the Dental-Nurse-Pharmacy Committee be accepted as presented.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 has reviewed the report of the Council on Allied Professions and Related Groups, and we move the adoption of the report of the Dental-Nurse-Pharmacy Committee as presented. (Motion was seconded and carried.)

Physical Medicine and Rehabilitation Committee, Kenton D. Leatherman, M.D., Louisville, Chairman

I am pleased to announce that there have been no particular problems that have arisen during the past year in this area, thus requiring no special meeting of this committee.

With the development of the new Medical Center at the University of Kentucky and the new Rehabilitation Building and Department under the sponsorship of the Kentucky Society for Crippled Children, I believe these factors will increase the interest in this area of medicine and probably as time goes on more activities and possibly more problems will arise in the future.

The orthopaedic group has ever been conscious of the need for physical medicine and rehabilitation and I believe in the future this phase of medicine will become more important to all phases of medicine and to all specialties.

Council Action: The Council recommends that the report of the Physical Medicine and Rehabilitation Committee be accepted as presented.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption of the Physical Medicine and Rehabilitation Committee as presented. (Motion seconded; carried.)

Infant and Maternal Mortality Committee, Barton L. Ramsey, M.D., Somerset, Chairman

This committee is a combination of pediatricians and obstetricians with the past record of sometimes meeting as one group. During the past year the subcommittees have been meeting separately. Robert McLeod, M.D., Chairman, and Helen Fraser, M.D., Secretary, of the Infant Mortality Committee have presented an interesting annual report as follows:

Data reviewed and analysed were as follows:

1. Trends in infant mortality for Kentucky and U. S. for ten year period from 1951-60.
2. Comparison of Kentucky's infant mortality rates for white and non-white with other states in U. S.
3. Infant mortality rates by county for 120 counties of Kentucky for white and non-white.
4. Comparison of neonatal/post-neonatal rates for Kentucky and counties of Kentucky.
5. Leading causes of infant mortality for state and individual counties of Kentucky.
6. Leading causes of post-neonatal deaths for the state of Kentucky.
7. Infant mortality rates by individual hospitals.
8. Percent of premature births for state, individual counties, and U. S.
9. Still birth rates for state, individual counties, and U. S.

Review of these data failed to reveal any obvious correlations with various factors existing within individual counties, eg., inadequacy of physicians, hospital beds, indigency figures, etc., so it was agreed that an intensive study of infant mortality within individual counties was indicated, particularly in those having exceptionally high rates over a period of years.

Also, the committee agreed to circulate question-

naires based on the Academy of Pediatrics "Checklist"* to all hospitals to obtain current information concerning nursery policies and procedures, even though there appeared to be no correlation between a hospital's score (based on similar questionnaires circulated in 1958) and its reported infant mortality rate.

A third step recommended by the committee was preparation of a guide for hospital nurseries based on the aforementioned publication of the American Academy of Pediatrics.

The committee also endorsed a hospital consultation program which will be instituted jointly by the State Department of Health and the University of Kentucky in the near future.

The maternal mortality committee met in Louisville, December 13, 1962, and discussed 12 cases. On May 9, 1963, they had a general meeting of some two hours in Lexington with the Kentucky OB and GYN Society and discussed 13 cases. It is the opinion of the chairman that the infant maternal death rate is declining in Kentucky. Statistics from the State Health Department may not show this for some time because of more complete reporting and investigating deaths. Doctor Helen Fraser and Doctor John Petry are working diligently for the Kentucky State Health Department and Kentucky State Medical Society.

The next meeting of the Maternal Mortality Committee is tentatively planned for August 26, 1963, at the Kentucky Medical Center.

Council Action: The Council recommends that the report of the Infant and Maternal Mortality Committee be accepted as presented. The Council further recommends to the House of Delegates, through the Board of Trustees, that they consider the advisability of having a copy of the minutes of each meeting sent to each member of the Infant and Maternal Mortality Committee. In addition, if it is not presently being done, the Council recommends that a letter indicating the committees findings be sent to the physicians whose case was reviewed.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption and implementation of the Report of the Committee on Infant and Maternal Mortality. (Motion seconded and carried.)

Tuberculosis Committee, Shelby L. Hicks, M.D., New Castle, Chairman

The Tuberculosis Committee met once during the year on May 16, 1963. The Committee discussed the over-all Tuberculosis Program in Kentucky and restated that the committee's 1962 report to the House of Delegates was primarily a statement of principles and goals of which most of these principles are being continued by one group or another. The committee went on record expressing interest in seeing the State Tuberculosis Coordinating Council reactivated and requested that M. Stuart Lauder, M.D., Director, T.B. Division, State Department of Health, question the appropriate officials and other participating organizations to see if all concerned would be willing to reactivate the Council which would serve as an advisory commission to the State T.B. Division.

The committee went on record in favor of continued state financial support, if at all possible, to the Covington-Kenton T. B. Hospital since a waiting list now exists at other State T. B. Institutions.

Since Kentucky's T. B. death rate is nearly 50% more than the national average, and since there are an estimated 4,000 unknown tuberculosis cases in Kentucky, your Tuberculosis Committee recommends that the Board of Trustees request that the KSMA Continuing Medical Education Committee and the members of that committee who have control over any Continuing Medical Education Programs give serious consideration to including an Education Program on Case Detection and Early Diagnosis of Tuberculosis in their over-all Medical Education Program.

Council Action: The Council recommends that the report of the Tuberculosis Committee be accepted as presented.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption of the Committee on Tuberculosis. (Motion seconded; carried.)

Blood Banks Committee, Marion F. Beard, M.D., Louisville, Chairman

No formal meetings of this committee were held this year.

The committee recommends to the Board of Trustees that they initiate inquiries to the Blood Banks Committee of the American Medical Association as to whether lay personnel or medical personnel should have final decision-making authority in the operation of the Community Blood Banks.

Council Action: The Council recommends that the report of the Blood Banks Committee be accepted as presented.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption of the Report of the Blood Banks Committee. (Motion seconded and carried.)

Industrial Medicine Committee, Leslie Van Nostrand, M.D., Louisville, Chairman

The Industrial Medicine Committee has held no formal meetings this past year and has no recommendations to submit.

Council Action: The Council recommends that the report of the Industrial Medicine Committee be accepted as presented.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption of the Report of the Committee on Industrial Medicine, as presented. (Motion seconded; carried.)

As chairman of the Council on Allied Professions and Related Groups, I would like to express my appreciation to the members of the Council and to the committee members who served under the Council.

Council on Allied Professions and Related Groups
Marion F. Beard, M.D., Louisville
Shelby L. Hicks, M.D., New Castle
Kenton D. Leatherman, M.D., Louisville
Leslie Van Nostrand, M.D., Louisville
Lloyd Yopp, M.D., Louisville
W. Donald Janney, M.D., Covington, Chairman

Recommendations, KSMA Board of Trustees

The Board of Trustees reviewed this report on August 8, 1963. The report, including all recommendations, was approved without dissent.

Recommendations, Reference Committee No. 4

Mr. Speaker, we move the adoption and implementation of the report of the Council on Allied Professions and Related Groups, with the exception of Paragraph 2, Page 1, dealing with the Board of Trustees appointment of all Committees and Councils, for the new year, prior to the KSMA Annual

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**Standards and Recommendations for Hospital Care of Newborn Infants.* American Academy of Pediatrics "Outline for Self-rating of Newborn Nurseries" Pages 137-140

Meeting of the current year. This was done because the Committee felt that the new Board of Trustees, which does not convene until late in the KSMA meeting, should have a voice in the appointment of these committees and councils, which will serve during their tenure of office. (Motion was seconded and carried.)

Report of the KSMA Representative on the T. B. Coordinating Council

To my knowledge the State T.B. Coordinating Council has not been active in the year 1962-63. I have received no notice of meetings or activities.

Shelby L. Hicks, M.D.
KSMA Representative

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption of the report of the State KSMA Representative on T.B. Coordinating Council, as presented. (Motion seconded; carried.)

Report of the KSMA Representative on Kentucky Health Council

During this past year the Kentucky Health Council, to my knowledge, has not been active.

There has been no meeting of the Council; and so far as I know, no election of officers, etc.

Carl Cooper, Jr., M.D.
KSMA Representative

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 moves the adoption of the report of the Kentucky Health Council as presented. (Motion was seconded and carried.)

Resolution D

Campbell-Kenton County Medical Society

WHEREAS there has been a movement toward mandatory indoctrination of new KSMA members on the state level and

WHEREAS the medical profession has traditionally supported and championed independence and individual freedoms, and

WHEREAS the proposal for mandatory state indoctrination may be construed, by some, as an encroachment on their freedom, Therefore be it,

Resolved, that the KSMA continue the policy of voluntary indoctrination on the state level and support the local indoctrination by written material for this express purpose.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee #4 considered Resolution D as presented by the Campbell-Kenton County Medical Society and moves that it not be accepted because it is in direct conflict with Paragraph 3, Page 2, of the President's Report and also Paragraph 3, Report #15, of the Council on Communications and Public Service, on which we have already voted. (Motion was seconded; carried.)

Mr. Speaker, I move the adoption of the report of Reference Committee #4 as a whole. (Motion was seconded and carried.)

Reference Committee No. 4
Paul J. Parks, M.D., Bowling Green, Chairman
Richard A. Allnutt, M.D., Covington
James W. Archer, M.D., Paintsville
N. L. Bosworth, M.D., Lexington
Paul E. Lett, M.D., Lancaster

REFERENCE COMMITTEE NO. 5

Russell L. Hall, M.D., Chairman
Reports on Medical Service

Report of the President

The AMA Board of Trustees members are limited to three three-year terms. The KSMA Trustee members are limited to two three-year terms. I would like to suggest that this House of Delegates recommend through our Advisory Commission to Blue Shield that the Kentucky Physicians' Mutual change their Bylaws to conform to the same general principle as the AMA. Furthermore, I would recommend that this program be implemented in the same manner as was employed in the changing of the system limiting the number of terms that can be served on the State Board of Health.

In the case of the members of Kentucky Physicians' Mutual Board of Directors, it would mean that present directors if re-elected, would be allowed to serve three terms after the new rule became operative. This change would relieve present Directors with long service records, of any sense of obligation to remain on the Board, and would give other able physicians an opportunity to be of service to Blue Shield and its thousands of policy holders. I have attended several Blue Shield Board meetings and I believe that each and every member is dedicated and each is doing a magnificent work.

Recommendations, Reference Committee No. 5

This committee was to consider two items of this report. Item #1 concerned the limiting to three three-year terms for members of the Advisory Commission to Blue Shield and the Kentucky Physicians' Mutual. This committee agrees with this recommendation in that it conforms to the same general principles as AMA trustees. The committee further recommends that consideration be given to the selection of candidates of the Board that are more representative of the wishes of the delegates of the KSMA.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Annual registration of physicians in the state should be considered so that we will know when a new man comes into the state or leaves either permanently or to take advanced training. One of the most used services of KSMA is providing information on the physicians in the state. Often the Association is embarrassed because under the present hit or miss system, it is not possible to maintain accurate records.

Recommendations, Reference Committee No. 5

Item #2 relates to the annual registration of physicans. It is this committee's recommendation that the State Board of Health establish regulations requiring all physicians to register annually.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and defeated.)

Report of the Council on Medical Services

Preface

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the Bylaws, which reads in part:

> ". . . . Each standing committee and council shall report annually at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments

or recommendations as the Board cares to make . . ."

The material in this report of the Council on Medical Service is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.
2. Reports of the committees of this Council with the Council recommendations following each committee report.
3. Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.

* * * * * *

The Council on Medical Services has met twice during this year, December 20, 1962 and June 13, 1963. At its first meeting the Council discussed the activities and plans for activities of the various committees serving under the Council. The committees serving under the Council are: Insurance Committee, Medical Discipline Committee, Mental Health Committee, Advisory Commission to Blue Shield, Advisory Committee to Blue Cross, Physicians Placement and Membership Committee, Medicare Review Committee, Federal Medical Services Committee, and the Committee on Aging.

The Council heard a presentation on the Keogh Law (Self-employed Individual Tax Retirement Act) which was passed in October, 1962, and which permits self-employed persons to establish retirement plans under certain specified conditions. No specific action was recommended by the Council at this time. In cooperation with the American Medical Association, the Council distributed a survey to all county medical societies and hospitals in the state on Utilization and similar committees designed to secure Optimal use of Voluntary Health Insurance and Prepaid Plans.

The Pike County Medical Society Resolution, introduced at the 1962 House of Delegates meeting, was referred to this Council for study and recommendations. At its June 13 meeting, the Council took the following action on the Pike County Resolution. "Because of our feeling that this resolution proposes an obstacle to the operation of Public Assistance and Kerr-Mills Programs which the Kentucky State Medical Association has endorsed, we disapprove of the resolution and further recommend that this action be approved by the KSMA Board of Trustees." The Council again discussed the Keogh Law and recommends that the KSMA Headquarters Office keep a file of information on the Keogh Law that can be readily available to the membership and that the membership be advised through regular means of communication that such is being done.

The following reports of the committees serving under the Council are herewith submitted:

Recommendations, Reference Committee No. 5

We agreed with the recommendation made earlier on this same subject in the President's Report that the directors of the Kentucky Physicians' Mutual be limited to a maximum of 3 three-year terms so as to conform with the same principles of the AMA.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried).

Insurance Committee, John Dickinson, M.D., Glasgow, Chairman

The Insurance Committee met April 18, 1963, in the KSMA Headquarters Office.

Letters have been received from two insurance companies requesting the committee to review charges submitted by five physicians, which the companies felt have been excessive. The committee acted upon all complaints received, and is pleased to report that the problems presented have been settled in a reasonable manner.

The concern of this committee one year ago was the undue demands for medical records made by an insurance company of the Muhlenburg Community Hospital. It has been reported to the Insurance Committee that these conflicts have been resolved.

There have been approximately twenty thousand copies of the standardized insurance form developed by the Health Insurance Council and approved by the KSMA House of Delegates in September, 1962, distributed to the KSMA members during the past associational year. The committee highly recommends that more physicians adopt the usage of this "short form" claim insurance form.

The Insurance Committee endorses the proposed KSMA Insurance Review Board appointed by the Board of Trustees and answerable to them directly, as a more efficient means to review complaints and recommends that it not be in addition to, but in replacement of this committee.

Council Action: It is recommended that the report of the Insurance Committee be accepted with the exception that the Council recommends to the Board of Trustees that the Insurance Committee be continued.

Recommendations, Reference Committee No. 5

The members of this committee accepted the insurance committee's action regarding the "Short Form" insurance claim and further recommends that the Insurance Committee be continued in order that further study may be given this matter.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded; carried.)

Medical Discipline Committee, Robert E. Pennington, M.D., London, Chairman

This committee was first appointed early in 1962 in response to resolutions submitted to the House of Delegates of the KSMA during its Annual Meeting the previous year. These resolutions requested more stringent rules and laws concerning medical discipline. This committee was requested to make studies of Medical Disciplinary Acts of other states and draw up recommendations for improved legislation which was to be presented to the Legislature of the Commonwealth of Kentucky after approval by the House of Delegates of the KSMA.

In correspondence with the Department of Medical Ethics and the Legal Department of the AMA it was learned that the Council on State Governments was at that time working with the National Conference of Commissioners on uniform state laws to draft a model medical practice act. Representatives of the AMA, the Federation of State Medical Boards, and others were acting as an advisory commission to the Council.

Consequently, last year this committee thought it advisable to await the report of this Council on State Governments and their recommendations as to a model medical practice act.

This committee has had recent correspondence with the Legal Department of the AMA relative to the Uniform Medical Practice Act and we were advised that this proposal was still in a tentative draft stage due to the length of time it takes to process proposed model legislation through the Commissioners on Uniform State Laws. However, a tentative draft will be presented to the Commissioners by the Advisory Committee when they meet in Chicago in August, 1963.

In view of these findings, this committee feels that this report should be awaited before any recommendations relative to legislation be made.

This committee would like to reiterate that it has no function other than studying and advising further legislation. However, the committee feels that since there are an increasing number of complaints concerning medical discipline that a committee should be appointed with authority to investigate and made recommendations to the Board of Trustees as to the

action which should be taken in these individual incidences.

Council Action: It is recommended that the report of the Medical Discipline Committee be accepted. With reference to the last paragraph of the report, the Council recommends that the present procedures concerning medical discipline be continued until more time for study has been made and further recommends that this committee be continued for the purpose of studying and making further recommendations in regard to the draft of the model medical practice act which is to be presented in August, 1963.

Recommendations, Reference Committee No. 5

This committee accepted the recommendations of the members of the Medical Discipline Committee.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Mental Health Committee, Frank M. Gaines, M.D., Louisville, Chairman

The Committee has held two meetings during the year. At its first meeting, it recommended to the Council on Medical Services, and subsequently to the Board of Trustees that the AMA Program for Mental Health be given approval and brought to the attention of the KSMA membership, and that the KSMA assist in the long range planning of the Kentucky Department of Mental Health.

At its second meeting, the Committee on Mental Health made the following proposals for consideration by the Council on Medical Services.

1. That the KSMA encourage the formation of mental health committees in each county medical society.
2. That County Medical Societies near state mental hospitals encourage their mental health committees to effect a closer liaison with the staffs of the state mental hospitals.
3. That the KSMA approve the amendment of the Kentucky Medical Practice Act to permit the full licensure of qualified foreign graduates (See Appendix A).
4. That the KSMA sponsor a Congress on Mental Health (See Appendix B).

Appendix A—Mental Health Committee

Summary of *Proposal* for Change of Medical Licensure Law for Foreign Medical Graduates

Problem:

1) It is virtually impossible for foreign physicians to obtain a full license in Kentucky.
2) Many highly qualified foreign physicians are leaving service in state mental hospitals to take positions elsewhere where they can obtain full licensure.

Recommendation: That the KSMA support amendments to the Kentucky Medical Practice Act to permit licensure of *qualified* foreign physicians as follows:

1) Require 2 years work in a U. S. Hospital.
2) Successful passing of the examination of the Educational Council for Foreign Medical Graduates.
3) Successful passing of regular Kentucky State Board licensing examination.

Appendix B—Mental Health Committee

Proposal for a Kentucky Congress on Mental Health

Sponsored by: Kentucky State Medical Association, Kentucky Psychiatric Association, Kentucky Department of Mental Health

Purpose:

1) To explore the problems of mental illness and health in Kentucky and consider plans for a program to solve these problems.
2) Plan how Kentucky physicians can be professional and community leaders in the mental health field.

Time: Late fall 1963—to last one day

Place: Louisville, Kentucky

Membership of Congress: Representatives from each County Medical Society; the Kentucky Psychiatric Association; Kentucky Department of Mental Health and related state agencies; other professional and lay organizations in the mental health field.

Program:

1) AMA Program for Mental Health
   Federal Proposals to aid Mental Health
   Current Planning Studies of Mental Health Needs in Kentucky
2) Small Discussion Groups to Consider These Programs
3) We hope that KSMA President could preside and that KSMA Staff assist in planning.

Cost: (Estimated)

Meeting Room	$ 50.00
Luncheon for 75 @ $3.00	225.00
Total Budget	$275.00

Budget to be split equally among 3 sponsoring groups.

Council Action: It is recommended that the report of the Mental Health Committee be accepted as presented. The Council further recommends that the portion of the report as pertaining to the Kentucky Congress on Mental Health receive final action from the Board of Trustees at its August 8 meeting so that plans for the Congress can be implemented immediately if the recommendation is approved.

Recommendations, Reference Committee No. 5

Members of this committee accepted the recommendations in this report with the exception that no change in the Medical Practice Act be made.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Advisory Commission to Blue Shield, W. Vinson Pierce, M.D., Fort Thomas, Chairman

The Advisory Commission to Blue Shield has held two meetings since the last previous report. These were on February 7, 1963, and on April 11, 1963.

At the meeting of the Board of Trustees of the KSMA which was held on March 6, 1963, several recommendations of the Advisory Commission were presented to the Board of Trustees for its consideration.

(a) The Senior Citizens Special Blue Shield Program

At the called meeting of the House of Delegates of the KSMA in April, 1962 when the Senior Citizens Program was approved by the House, a proviso was made that Blue Shield should report to the House of Delegates in April of each year concerning the progress which the program had made.

Since the Senior Citizens Program was not put into operation until April of 1963, the KSMA Advisory Commission to Blue Shield recommended that this report be made on a calendar basis each year. This recommendation was approved by the Board of Trustees.

(b) Promotion of Senior Citizens Program

The Board of Trustees approved the recommendation of the Advisory Commission that a letter be written to each trustee to solicit his cooperation in promoting participation in the Senior Citizens Program.

It was noted that as of February 1963, approximately 50 percent of the physicians who would be taking care of the aged group were signed up as participating physicians in the program; and that there were more than 1800 subscribers to the program.

(c) Specialty Representation on the Board of Directors of Kentucky Physicians Mutual

The KSMA Board of Trustees approved the recommendation of the Advisory Commission, that a reasonable balance of representation of the various physicians specialties be placed on the Board of Di-

rectors of Kentucky Physicians Mutual. This recommendation will be referred to the Board of Directors of that body.

(d) Blue Shield Insert in the Journal of the KSMA

The Board of Trustees approved the recommendation of the Advisory Commission that a special Blue Shield insert be placed in the Journal of the KSMA, probably in the early fall. The expenses of this insert will be paid by Blue Shield. The purpose of this insert will be to better acquaint the physicians of this state with the work which their Blue Shield plan is doing.

(e) Insurance Review Board

The Advisory Commission to Blue Shield, at its meeting on February 7, 1963, discussed possible methods for helping to control abuses of insurance and prepayment funds, in the forms of increased and unwarranted utilization of hospital services, as well as in the rendering of excessive fees to patients who are known to have insurance coverage. Such abuses are felt to occur infrequently, but their existence must be admitted, and it creates many problems. The Advisory Commission, following a suggestion made by Alfred Miller, M.D., voted to request the Board of Trustees to create an Insurance Review Board, whose function would be to help control abuses or unsound practices, whether these were committed by physicians, by the utilizers of the services, or by the prepayment organizations.

At the meeting on March 6, 1963, the Board of Trustees approved in principle the creation of such a Review Board, and directed that further study be made by the Advisory Commission concerning the structure and functions of the proposed Board.

On May 23, 1963, a study conference was held, to which representatives of the medical profession, especially of various specialty groups; of Blue Shield, the Insurance Industry, and other interested groups were invited. With the help of the many excellent suggestions which were made at this study conference, a set of definite proposals for the formation of the Review Board were drawn up, and were approved by the Board of Trustees at its meeting on June 6, 1963.

The stated purpose of the Insurance Review Board shall be to represent the Board of Trustees in dealing with pertinent matters concerning Health Insurance, and in general, to help ajudicate those cases where insurance companies or other prepayment organizations, patients and physicians, cannot agree on the proper fees for given services, or on the necessity for the utilization of services, in certain cases. Complaints against insurance companies made by patients or physicians may likewise be referred to the Insurance Review Board, if satisfactory adjustments can not be reached otherwise.

The Board will serve under direct control of the Board of Trustees of the KSMA, and it will have the authority to conduct investigations and to make recommendations for appropriate actions.

The KSMA Advisory Commission to Blue Shield wishes to express its appreciation to the Board of Trustees of the KSMA for its help in implementing the above recommendations and for its generous support and encouragement in all of the work of the Advisory Commission.

We also wish to thank the Executive Secretary of the KSMA, Mr. J. P. Sanford, and his fine staff, for their invaluable help in conducting the work of the Commission.

The Chairman of the Commission is most grateful to the other members of the Comission for their interest and enthusiasm in studying the problems which were presented to us.

Council Action: It is recommended that the report of the Advisory Commission to Blue Shield be accepted as presented.

Recommendations, Reference Committee No. 5

Members of this committee recommend that this report be accepted.

Mr. Speaker I move the adoption of this section of the report. (Motion was seconded; carried.)

Physician Placement and Membership Committee, Claude E. Cummins, Jr., M.,D. Maysville, Chairman

Membership was added to our Committee this year by the KSMA Board of Trustees since placement and membership are somewhat related. Our Committee now attempts to help doctors seeking locations, aid physicians in finding associates, and cooperate with communities if they can support a doctor. As to membership, we hope to encourage more eligible doctors in Kentucky to become members of KSMA and AMA.

Physician placement by our Association has been active and has proven to be a much needed service to physicians wanting associates and doctors wanting to locate in Kentucky. The service is growing rapidly as more doctors throughout the State find out it is available. Also, interns, residents, doctors getting out of the armed forces and doctors from other states are depending on the service for their best source of information when considering a location.

It is estimated that over two hundred requests were handled by our Headquarters staff this year made by physicians wanting associates, those seeking locations, and communities wanting physicians.

With reference to memberhip, our Committee thinks most physicians in our State expect KSMA Headquarters to have up-to-date information on all members and non-member physicians in Kentucky. It is only good business that any organization have adequate records of its members or potential members for effective and efficient operation. After reviewing the method by which the staff gets its membership information, we find the source to be inadequate. Once a physician gets a license through the Division of Licensure and Registration of the State Department of Health in Frankfort to practice in Kentucky, he has no legal obligation to inform the Division, or the Medical Association where he will practice. He can move from county to county, leave the State and return as many times as he wishes, and do this without either reporting to the Division of Licensure or the Headquarters Office. With this method of keeping up with our doctors, we cannot expect our membership department to have accurate records on all practicing physicians in our State.

Our Committee decided that the best solution for this problem would be to have annual registration of physicians and that this be done by the Licensure Division of the State Board of Health. After checking with Russell E. Teague, M.D., Commissioner of Health, we find that his Department can require annual registration by regulation instead of legislation, which will have the effect of law, and this can be done without an annual registration fee. Some of the reasons we need better records are:

1. The Indigent Medical Care Program requires the signature, license number and other information before any reimbursement can be made. On numerous occasions vendor physicians have been delayed payment for their services until such time as this information could be received.
2. Practically all other professions in Kentucky have annual registration of their members.
3. KSMA contracts with the Veterans Administration for Hometown Medical Care and it is not unusual for the Veterans Administration to request information from the Headquarters Office on certain doctors.
4. Seldom a day passes but what the Headquarters Office receives calls from someone asking for such information as the full name of a physician, where and how long has he practiced in

the present location, and is he a member of KSMA and AMA.

5. The various specialty organizations frequently contact the office to find out the number of specialists and the town and county in which they practice.
6. Headquarters Office is often called upon to address envelopes for announcements of doctors. On many occasions, doctors have been critical of the office when they have a large number of letters returned because they were not given the correct address.
7. The office gets calls from physicians or lay people from other states asking for leads on physicians that might be practicing in Kentucky.
8. The Alumni Office at U of L depends on the Headquarters Office for much of their information on medical alumni.
9. It is expensive to have letters, journals, and other material returned when sent to the wrong address. It is also embarrassing to the Headquarters Office. It makes it appear that due care has not been exercised in keeping the records current.

Our Committee does not feel that our Medical Association and the Division of Licensure should have to depend upon newspaper clippings as their best source of information on doctors entering practice for the first time, changing locations, and for notification on those who have died. For the reasons mentioned above and many others, our Committee strongly recommends that our KSMA House of Delegates authorize Doctor Teague to establish a regulation in his Department making it compulsory for all physicians to register annually and that this be done without charging a fee.

Council Action: It is recommended that the report of the Physician Placement and Membership Committee be accepted as presented.

Recommendations, Reference Committee No. 5

We recommend that this report be accepted with the requirement that annual registration of physicians be adopted. Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and defeated.)

(It was then moved and seconded to adopt the report of the Physician Placement and Membership Committee as amended.) (Motion carried.)

Advisory Committee To Blue Cross, Sam A. Overstreet, M.D., Louisville, Chairman

Your Medical Advisory Committee to the Blue Cross Hospital Plan, Inc., of Kentucky has held one meeting each month during the current year. The purpose of these meetings is to review questionable or controversial claims that have been submitted to the Blue Cross by physicians. We have further considered certain irregularities that have been called to our attention in various hospitals over the state and recommendations have been ordered for the correction of such abuses.

A full meeting of the committee is planned prior to KSMA Convention in September and it is hoped that certain positive recommendations will be affected at such a meeting.

The chairman of this committee feels that a change of chairmanship in the committee would be a healthy thing for the coming year.

Council Action: It is recommended that the report of the Advisory Commission to Blue Cross be accepted as presented. The Council wishes to commend Sam A. Overstreet, M.D., for his long and faithful service as chairman of this committee.

Recommendations, Reference Committee No. 5

It is recommended that this report be accepted.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded; carried.)

Medicare Review Committee, Henry Collier, M.D., Louisville, Chairman

During 1962, the Medical Review Committee reviewed and acted upon approximately 150 special report cases. The total number of medicare cases in Kentucky during this same period was approximately 5,000.

The committee held one meeting this year with representatives of Blue Cross-Blue Shield and representatives of The Office of Dependents Medical Care, Washington, D.C.

The background of Medicare was reviewed, the procedures followed in evaluating controversial Medicare claims were discussed in detail, Kentucky Physicians' Mutual's role as fiscal administrator was explained and a number of sample claims were studied.

The committee expressed its appreciation in the fulfillment of its recommendation as submitted last year, namely the addition of representatives from Orthopedic Surgery, Internal Medicine, and Neurosurgery to the Medicare Review Committee.

It was agreed to continue the policy of distributing claims among the committee members according to their specialty in order that the claims needing review can be considered by a physician in the proper specialty.

Council Action: It is recommended that the report of the Medicare Review Committee be accepted as presented.

Recommendations, Reference Committee No. 5

Your reference committee recommends that this report be accepted.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded; carried.)

Federal Medical Services Committee, L. F. Beasley, M.D., Franklin, Chairman

The Federal Medical Services Committee has been in frequent communication with the Federal Government concerning minor changes that have been made in the Federal Services contracts. These changes have been published in the KSMA Journal.

A meeting of this committee was held with representatives from the Veterans Administration and with Blue Shield representing the Medicare Contracts February 7, 1963. The various Federal Government contracts and the Medicare Contract were discussed at some length. No areas of difficulty or dissatisfaction were reported and a very amiable and congenial meeting resulted.

Council Action: It is recommended that the report of the Federal Medical Services Committee be accepted as presented.

Recommendations, Reference Committee No. 5

Your reference committee recommends that this report be accepted.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded; carried.)

Committee On Aging, Earl P. Oliver, M.D., Scottsville, Chairman

The KSMA Committee on Aging met once during the associational year on April 25, 1963.

At its meeting, the committee approved the suggestion of sending the booklet "A New Concept of Aging" to all Kentucky Senior Citizens groups along with a letter signed by David M. Cox, M.D., KSMA President.

The committee feels that the public is still not very well informed on the Blue Cross-Blue Shield "Senior Citizens Program" and suggests that an article on this appear in the KSMA Journal.

The chairman had the pleasure of representing KSMA and the Committee on Aging at the Third National Conference of the Joint Council to Improve the Health Care of the Aged at San Francisco, Cali-

fornia, in May of this year. A report on this conference has been submitted to the chairman of the Council on Medical Services and a brief report of the conference will appear in an issue of the Secretary's Letter.

"Our committee recommends to the Council on Medical Services that:

1. We express our appreciation in the way that the Kerr-Mills Program has been administered in Kentucky. In addition, we feel that a provision should be made in the Kerr-Mills Law to take care of protracted illness upon the recommendation of a screening committee.
2. We commend the Kentucky State Legislature and Governor Combs for their advanced thinking and planning in establishing a Pilot Program to provide low cost housing for the healthy aged, establishment of Waverly Hills Geriatric Center, and making more liberal the provisions of Kerr-Mills Programs.
3. We study our State and Local communities and solve all of our problems on a local level when possible.
4. The KSMA give its full support to the AMA's Eight Point Program for the Aged.
5. We encourage citizens, as they advance in age, to make more uses of their experience and skills as employees and teachers, and that we discourage retirement on a basis of age only.
6. We encourage older people to become useful and interested in voluntary and part-time work and in community and church affairs.
7. We encourage and assist the senior citizens in peventing illness and preserving health by having periodic physical examinations, and we provide health care information for the senior citizens.
8. We encourage the senior citizens to remain members of the family group, and not be segregated because of their age.

After having a vote of confidence by our national legislators in defeating the Socialistic and Compulsory King-Anderson Bill in 1962, and a like vote of confidence by our Kentucky voters in defeating the Senatorial Candidate who supported this bill in 1962, we wish to again reaffirm our belief that in keeping with American Traditions: the average American Citizen is able and willing and furthermore wishes to provide for his own medical care and other needs through voluntary facilities, and does not wish to become a ward of the State. Further, that those who are actually not able to provide for their own needs, through no fault of their own, can adequately be cared for on a local level through Kerr-Mills Programs."

Council Action: It is recommended that the report of the Committee on Aging be accepted as presented.

The chairman of the Council on Medical Services would like to express his sincere appreciation to the committee chairmen, the committee members, and to those who have served on the Council on Medical Services.

Council on Medical Services
John Dickinson, M.D., Glasgow
Earl P. Oliver, M.D., Scottsville
Sam A. Overstreet, M.D., Louisivlle
W. Vinson Pierce, M.D., Fort Thomas
Claude C. Waldrop, M.D., Williamstown, Chairman

Recommendations, Reference Committee No. 5

Our committee recommends the approval of this committee's report.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Recommendations, KSMA Board of Trustees

The Board of Trustees reviewed this report on August 8, 1963.

This report was approved with the exception of the report of the Mental Health Committee. The Board recommends that Appendix A of the Mental Health Committee which pertains to the "Summary and Proposal for Change of the Medical Licensure Law for Foreign Medical Graduates" be not approved. The remainder of the report of the Mental Health Committee including Appendix B which pertains to a proposal for a Kentucky Congress on Mental Health was approved by the Board.

Report of Board of Directors, Kentucky Physicians' Mutual, Inc.

The Board of Directors of Kentucky Physicians' Mutual, Inc. respectfully presents its annual report to the Kentucky State Medical Association. It reflects the fourteenth year of operation and service to the people of Kentucky.

As of July 31, 1963, 810,661 people were members of the Plan, an increase of 45,804 over the membership one year ago. In addition, 33,003 persons are now also enrolled in our Extended Benefits program and 8,737 persons in the Major Medical coverage. During the 12-month period ending June 30, 1962, $7,187,515.68 was paid to physicians. This is an increase of $621.598.19 over the previous 12-month period. Calendar year 1963 payments to physicians will exceed $8,300,000.

The cost of operation for the year ending June 30, 1963 was 10.6% of income. We continue to rank favorably with other Blue Shield Plans with respect to operating cost in that only 11 of the 75 Blue Shield Plans operated at less administrative cost per member than the Kentucky Plan.

During the month of October, 1962, a special program for Senior Citizens was offered to all Kentuckians over age 65. The program was developed in cooperation with the AMA, and it embodied the principle of service benefits to those applicants whose incomes do not exceed $2500 for a single person and $4000 for a family person. Approval of this program was given by KSMA House of Delegates on April 12, 1962. One-thousand Kentucky physicians have signed participating agreements for this program. 1,846 persons over 65 are now enrolled in this program. 825 of those are more than 75 years old.

Two new certificates in which the schedules of indemnities are based on the Professional Service Index were adopted. The schedules reflect a more equitable relation between indemnities and generally will result in an increase in payments to physicians. The new schedules are being offered to all new applicants in place of the Standard and Preferred Certificates. Every individual subscriber has already been contacted and urged to change to the new schedules. All groups are being urged to change as their renewal dates occur. We are hopeful that a large percentage of our membership will soon be covered by the new certificates.

Because of the fact that many of our larger groups were using a disproportionate share of benefits, it became apparent that an adjustment in the rating principles should be made. After extensive study and consultation with our actuaries the Board adopted a new method of establishing the dues members shall pay. The use of the benefits by each group is reflected in the dues established for the group. The cost of benefits is thereby more equitably distributed to those who use them most. This rating principle was approved by the Commissioner of Insurance and was placed into effect in June of this year.

In closing I want to express my sincere appreciation to members of the profession who have cooperated and have assisted in the development of the Senior Citizens Program, our new schedules and rating programs during this year of major changes. My deep appeciation is also expressed to members of the

Board, fellow officers and the staff for their assistance in making this one of the most progressive years in our history.

William H. Cartmell, M.D.
President

Recommendations, Reference Committee No. 5

The members of this committee accepted report No. 29 as given; however, it is felt that additional studies on medical indemnities based on the Professional Services Index should be included in their new schedules.

Mr. Speaker. I move the adoption of this section of the report. (Motion seconded and carried.)

Report of Board of Trustees, Rural Kentucky Medical Scholarship Fund

Each year the Rural Kentucky Medical Scholarship Fund continues to grow, both from the standpoint of adding new recipients to the present number and enlarging the Fund with additional dollars.

During the annual meeting of the Scholarship Board of Trustees on May 1, ten new applicants were interviewed and approved for first loans. Adding this number to the (14) sophomores, (17) juniors and (12) seniors, this makes a total of (53) recipients in medical schools for the 1963-64 school year.

The present State Administration gave $30.000 to the Program in July and this amount, plus that returned by recipients to the revolving fund, made it possible to loan each student participating in the Program $1,200 for this year. The trustees are looking forward to the time when enough money can be loaned each applicant to make this Program the major source of funds the student will use to finance his or her medical education.

Beginning this fall (53) recipients of the Fund will be attending five different medical schools. Number and schools are as follows:

(25) University of Kentucky
(23) University of Louisville
(3) Tulane University
(1) University of Tennessee
(1) St. Louis University

Only residents of Kentucky are eligible for loans.

Including the ten first loan applicants, (245) students have received money from the Fund since its beginning in 1946. Ninety-nine are now practicing in Kentucky. During the past year eight recipients located in areas approved by the Board and eight were drafted into military service. Jackson and Wolfe counties, two of the ten most critical ones in need of doctors, were each successful in getting a Scholarship recipient who completed his internship in July.

An expression of appreciation is due the members of the Scholarship Board of Trustees for their devotion and enthusiasm in the Program.

Rural Kentucky Medical Scholarship Fund
C. C. Howard, M.D., Chairman
Board of Trustees

Recommendations, Reference Committee No. 5

The members of this committee accept this report and wish to commend the trustees of the scholarship fund on an excellent job well done.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of Advisory Committee to Selective Service

The need for physicians placement in the Armed Forces during the past year has not been heavy.

The Committee has investigated all cases referred to it by the State Selective Service Office of physicians where deferment has been requested. The Committee has enjoyed the full cooperation of the profession at the local and state level in obtaining information on which to base its recommendations.

The Committee is very appreciative of the close working relationship with the State Selective Service Office and its director, Colonel Everett L. Stephenson. The Committee has been impressed with Colonel Stephenson's interest in maintaining the proper health care level in all Kentucky Communities.

Advisory Committee To Selective Service
Charles B. Billington, M.D., Paducah
O. B. Coomer, D. D. S., Louisville
Glenn U. Dorroh, M.D., Lexington
Sydney G. Dyer, M.D., La Center
F. E. Hull, D. V. M., Lexington
Frank Jordan, D. D. S., Louisville
A. Clayton McCarty, M.D., Louisville
Lula B. McClain, R. N., Louisville
Sam A. Overstreet, M.D., Louisville
Marcus Randall, D. D. S., Louisville
Russel E. Teague, M.D., Frankfort
L. O. Toomey, M.D., Bowling Green
J. Duffy Hancock, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 5

The members of this committee accepted report No. 31 as presented.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of Technical Advisory Committee on Indigent Medical Care

Because the Governor's Advisory Council for Medical Assistance Program is required by law to meet every three months, it is important that our KSMA Technical Advisory Committee have several meetings so the Medical Association's views can be made known to the Council. The Technical Advisory Committee has met three times since the House of Delegates meeting. Your Chairman, or his designated representative, appeared before the Council and made the Committee's report on recommendations and suggestions.

Our relationship with the Governor's Advisory Council, the Division of Medical Care of the Health Department, and the Department of Economic Security has been pleasant, reasonable and workable. Upon request, representatives of the two departments will meet with our Committee and we reciprocate with them in like manner. Generally speaking, our Committee is pleased with the progress and operation of the Kerr-Mills Program. We agree in principle that liberality is desirable, but it should be based on individual need rather than blanket coverage of all persons.

Our report to the Governor's Advisory Council on July 17, 1963 asked the members to study and where feasible give favorable consideration to the following:

1. That extended hospitalization for certain serious medical conditions be made possible on the advice of, and request of, the attending physician and the involved hospital . . . Such requests being subject to review by a local review committee when requested.
2. That the existing National and State laws and operating regulations be reviewed to determine whether or not catastrophic illnesses which deplete rapidly the reserves of a non-eligible participant would permit the individual to become eligible if this catastrophic illness reduces their income or resources to an eligible level.
3. While this Committee feels very strongly that service pertaining to the health needs of our people based on need should continue, we are ready, and we are sure we represent the feeling of other technical advisory committees, to assist in advance in planning such expansions.

4. We would like to repeat these former recommendations—
   a. That emergency surgery and anesthesia be made compensible along with emergency-medical and obstetrical problems
   b. That consultants be paid for their services on request of an attending physician
   c. That specialists be paid for their services, including pathologist and radiologist
   d. That further study be made to determine the feasibility of entering into a contractual arrangement with Blue Cross-Blue Shield, or some competent insurance carrier.
5. It has come to our attention through several doctors that some difficulty is being experienced in securing prescription drugs in certain instances. It is our hope that such discrepancies as exist can be erased through a better understanding of all participants concerned.

Only two of our counties do not have physicians participating (in varying degrees) in the Program. Since the Medical Assistance Program has the endorsement and support of KSMA and the fact that it is based on need, we hope that more physicians will become increasingly active. Kentucky's Program is being observed and scrutinized by numerous people in and out of the Commonwealth, and several states have requested copies of our Bill that became law to use as a guide for their legislation. Realizing that many physicians need more information on the Medical Assistance for the Aged (MAA) and Public Assistance (PA) programs, our Committee requested the Editor of The KSMA Journal to allocate necessary space for an appropriate article. This information can be found in the January 1963 issue.

The 1962 House of Delegates considered Warren County Medical Society's Resolution "O" and referred it to our Committee for study and use. The adjustments in the Program as suggested by the resolution were considered as follows:

1. That there be no drug list, special prescription blanks, or similar restrictions of treatment by a physician licensed by the Commonwealth and that ordinary usual prescriptions for recipients of this aid be filled by qualified pharmacists at a fee agreeable to them and the Administration upon certification of their eligibility for this aid by the proper agency.

It is assumed that the Warren County physicians felt that a limited drug list would restrict their practice. The Director of the Division of Medical Care commented on this and said an effort had been made not to have omissions of drugs wanted by physicians, but, it was agreed, if the drug list were done away with, the Program probably could not bear the expense. He said it was felt that special provisions could be made if certain drugs were not on the list. It was stated that the special prescription form is the main objection. The Director said this form is under consideration and a new one is being designed which should be more satisfactory. He said it would have less information for the physician to fill out. In regard to the "fee agreeable to the pharmacist" it was stated that this had been worked out through the Division of Medical Care and the pharmacists and this is not a concern of this technical committee.

2. That consent forms be executed by the patient before the diagnosis of his illness and the treatment thereof are divulged to third parties.

The Director said the diagnosis will be deleted from the revised prescription form, however, he said in case of the physicians' services it would be required on the form because there are some services for which the Program will not pay.

3. That physicians' fees be eliminated from the program

This Committee and KSMA are on record as saying physicians should be paid for their services if the Program will permit and would not be in favor of taking the fee away completely.

4. That funds so conserved be utilized in other areas of this Program (See comment under item 3.)

5. That a committee continue to study the employment of Blue Cross-Blue Shield as a fiscal agent for this Program and report its findings to the House of Delegates.

Recommendations made by the Technical Advisory Committee to the Governor's Advisory Council states "that further study be made to determine the feasibility of entering into a contractual arrangement with Blue Cross-Blue Shield, or some competent insurance carrier."

KSMA Technical Advisory Committee
To The Medical Assistance Program
George Estill, M.D., Maysville
Donald Graves, M.D., Frenchburg
G. David McClure, M.D., Louisville
Claude C. Waldrop, M.D., Williamstown
Clyde C. Sparks, M.D., Ashland, Chairman

Recommendations, Reference Committee No. 5

The members of this committee accepted this report as it was presented.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Resolution B

Campbell-Kenton County Medical Society

WHEREAS, the principle of free choice of physician and fee for service is the standard for medical practice in Kentucky, designed to preserve a doctor-patient relationship of the highest quality, and to make each physician fully responsible for his acts and,

WHEREAS, the medical profession has always cared for patients regardless of race, creed, or economic status, and shall continue to do so, and,

WHEREAS, the physician alone is legally and morally responsible for the quality of medical service and,

WHEREAS, a third party can do no more than to qualify a patient to receive funds for medical services rendered and

WHEREAS, the medical profesion pledges itself to the preservation of principles which have resulted in medical service of the highest quality, Therefore be it

Resolved, that the KSMA urge that all members participate in new third party plans for payment of medical expenses only to the extent that they provide medical services as needed and bill the patient for such services. The patient will then negotiate if necessary with the third party for monies due or available.

This will maintain and thereby assure freedom of choice of physician and maintain individual responsibility.

We further recommend that this resolution be sent to the AMA House of Delegates for consideration.

Recommendations, Reference Committee No. 5

"*Resolved*, that the KSMA urge that all members participate in new third party plans for payment of medical expenses only to the extent that they provide medical services as needed and bill the patient for such services. The patient will then negotiate if necessary with the third party for monies due or available.

This will maintain and thereby assure freedom of choice of physicians and maintain individual responsibility.

We further recommend that this resolution be sent to the AMA House of Delegates for consideration.

It is the recommendation of this committee that this resolution be sent to the Board of Trustees of the KSMA for their final dispensation and for any action as they see fit."

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Resolution F

Campbell-Kenton County Medical Society

WHEREAS recent Blue Cross plans have included physician services, such as Radiology and Pathology in their contracts and

WHEREAS such services are truly physician services and

WHEREAS separation of physician function from hospital function is essential to maintain the free practice of medicine and

WHEREAS control of one group of physicians for a hospital may eventually lead to control of all physicians and their fees, Therefore be it

Resolved, that the KSMA recommends to the Blue plans that *any* and *all* policies issued make a clear distinction between hospital and physician services with Blue Shield paying the physician services.

Recommendations, Reference Committee No. 5

"*Resolved*, that the KSMA recommends to the Blue plans that *any* and *all* policies issued make a clear distinction between hospital and physician services with Blue Shield paying the physician services."

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded; carried.)

Resolution J

Jefferson County Medical Society

WHEREAS, the Kentucky Committee for Correctional Research, A Citizens' Group interested in Penal Reform in the Commonwealth of Kentucky, has caused the National Council on Crime and Delinquency to study the Kentucky Penal and Parole Systems; and

WHEREAS, the report of the National Council on Crime and Delinquency concerning this study has been well received by the citizens of the Commonwealth, because of the thoroughness in examining the deficiencies of the present penal and parole systems; and

WHEREAS, the report of the National Council on Crime and Delinquency makes recommendations concerning the penal and parole systems which would result in the more humanitarian administration of justice; and

WHEREAS, the report of the National Council on Crime and Delinquency has recommended the improvement of the medical and dental care of the prisoners in the Commonwealth; therefore

BE IT RESOLVED, that the Kentucky State Medical Association does hereby commend the National Council on Crime and Delinquency and the Kentucky Committee for Correctional Research for their work in the preparation of the report on the penal and parole systems and the special session of the General Assembly for implementing this into law; and

BE IT FURTHER RESOLVED, that the Kentucky State Medical Association does hereby recommend to those responsible for the medical and dental health of the prisoners in the Commonwealth, that the improvements called for in the Report concerning the medical and dental care of prisoners be adopted.

Recommendations, Reference Committee No. 5

"*Resolved*, that the Kentucky State Medical Association does hereby commend the National Council on Crime and Delinquency and the Kentucky Committee for Correctional Research for their work in the preparation of the report on the penal and parole systems and the special session of the General Assembly for implementing this into law; and

Be it further resolved, that the Kentucky State Medical Association does hereby recommend to those responsible for the medical and dental health of the prisoners in the Commonwealth, that the improvements called for in the report concerning the medical and dental care of prisoners be adopted."

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded; carried.)

Resolution L

Muhlenberg County Medical Society

WHEREAS, the Board of Trustees, in February in advising on a particular problem in area medical care, recommended among other things—

1. That patients have unrestricted free choice of physicians.
2. That patients and physicians alike have free choice of hospitals, and

WHEREAS, this represents the spirit of the practice of medicine on an open basis, with physicians and hospitals competing for patient favor on the basis of the quality of services rendered, and

WHEREAS, those especially expert in the important psychosomatic diseases uniformly report that patients improve more rapidly in an environment of trust and confidence in the therapist, and

WHEREAS, these principals follow the traditional development of our profession on the basis of individual physician responsibility, which has rewarded our sick with the lowest mortality rate in history, and

WHEREAS, capitation schemes, with which we are familiar as the list or cut-off, have proven a source of wide-spread patient exploitation and other evils throughout the State,

BE IT THEREFORE RESOLVED, that the Kentucky State Medical Association, at this House of Delegates, specifically endorse the pronouncement of our Board of Trustees, and specifically state our belief that the sick are best served where:

1. There is free choice of physician.
2. There is free choice of hospital.
3. The laborer is held worthy of his hire, and the physician is rewarded with fees for his services.

Recommendations, Reference Committee No. 5

"*Be it therefore resolved*, that the Kentucky State Medical Association, at this House of Delegates, specifically endorse the pronouncement of our Board of Trustees, and specifically state our belief that the sick are best served where:

1. There is free choice of physician.
2. There is free choice of hospital.
3. The laborer is held worthy of his hire, and the physician is rewarded with fees for his services."

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Mr. Speaker, I move the adoption of this report as a whole as amended. (Motion seconded and carried.)

Reference Committee No. 5
Russell L. Hall, M.D., Prestonsburg, Chairman
William W. Hall, M.D., Owensboro
Andrew M. Moore, M.D., Lexington
Lewis E. Wesley, M.D., Liberty
Robert L. McClendon, M.D., Louisvile

REFERENCE COMMITTEE NO. 6

M. Randolph Gilliam, M.D., Chairman
Reports on Constitution and Bylaws;
Special Committees

Report of the Advisory Committee to the Editor

The chief problem of the *Journal* this year has been income. As shown in the graph below, advertising revenue has fallen by half ($25,000) from the record year of 1960. (more detail in financial summary, last page). In a commercial publication, this would have been disastrous. To the Association it has meant an increase in *Journal* cost of about $12 per member annually.

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GROSS INCOME—JOURNAL KSMA

88% of *Journal* income is derived from advertising placed by national advertisers, predominately the national ethical drug houses. These have felt the pressure of the Senate investigation of the drug industry to the greatest extent. Remembering Senator Kefauver's observation that the drug manufacturer furnished physicians with incomplete scientific information, it is interesting to find KSMA's burden for its scientific publication increased as a result of his Committee inquiry.

The national drug manufacturers have extensively re-examined their advertising policy since the Kefauver investigation and the thalidomide controversy. Recognizing that the general effect of the Food and Drug Administration legislation will be to freeze out small producers, the large manufacturers are feeling the need of a better projection, or image in the public mind. They are tending to divert advertising dollars to foundations and scholarships, rather than using the dollars for direct promotion of specific drug products to the profession. In an unsettled political climate, they are seeking security in a benign competitive level above huckstering, yet short of the anti-trust laws.

The advertising industry recognizes 387 publications as medical journals. These are classified as 40 national, 41 state, 133 county bulletins, 29 Academy of General Practice and 144 designated as specialty journals. Some page-rate information is included in the statistical summary on the last page to illustrate the competitive aspects of the struggle for a decreasing stock of advertising dollars.

Most of our advertising is secured through the cooperative State Medical Journal Advertising Bureau. Our *Journal* has received an appropriate portion of the advertising billed through this agency.

In appraising alternate sources of revenue from national advertisers, the obvious markets are the consumer-goods producers (automobiles, tobacco and liquor, etc.) These organizations feel that physician purchases are adequately stimulated through advertising in general consumer-goods media.

The other potential source of revenue is the local advertiser. His budget and ads tend to be smaller, and his space need less regular. Consequently, the cost of selling such space consumes a much larger portion of the revenue dollar than does the account with national advertisers. The Committee has suggested further exploration of this possibility, recognizing that higher agency commissions may be necessary to secure capable representation.

Cost-cutting in the interest of reducing *Journal* operating costs, is not a fertile field. The *Journal* has never operated in a luxurious manner. Authors are not furnished with free reprints. The only Editorial salary expense is $600 per year, barely covering the out-of-pocket expenses of the Scientific Editor. Operating employee salaries are at the minimum competitive rate in the local labor market. Only incidental salary savings amounting to $1,350 were possible during the year. Mild restrictions on lineage have been placed on some monthly Departments, with a saving of a few pages.

Actual printing costs are already well in hand, comparing favorably with those of other medical journals, and of publications with comparable circulation covering other fields.

EDITORIAL CONTENT

For four years, Doctor Sam Overstreet has had the help of Doctor George W. Pedigo as Assistant Editor. Other interests led Doctor Pedigo to resign. Doctor Walter S. Coe, Associate Professor of Medicine at the University of Louisville, was designated by the Trustees to help carry on the scholarly tradition. Doctor Eugene Conner, of Louisville, has become Book Review Editor.

A new cover design, purchased last year, has been phased into production, and has received considerable favorable comment from both local and national connoisseurs.

Sixtieth Anniversary issue is in the active planning stage.

The Committee has considered, with the Editor, various requests for special issues, and for special uses for space. We have felt, in general, as much space as practical should be left uncommitted, for contributions on the basis of individual merit. It was felt that the *Journal* pages should be open to research papers and reports by both students and residents, again on the basis of merit. Emergency Medical Service was thought to be of sufficient importance to merit an exclusive issue. The annual Symposium issue this year is under the editorship of Doctor Beverly Towery, and will be on "Endocrine Disease."

The Committee invites Association attention to the progress of the *Journal* under the leadership of Doctor Sam Overstreet. For four consecutive years, in national competition, it has been included among the list of ten best State journals. Our Managing Editor has been accorded the honor, quite unusual for a layman, of serving as Chairman of the National Conference of the Bureau of State Medical Journals to be held on October 21st and 22nd.

The Editors have continued their efforts for the improvement of the scientific content of the *Journal*, seeking material that will be specifically helpful to the practicing physician. They have encouraged the development of authors within the Association, while still obtaining contributions by distinguished authorities from other areas of the country, lest the *Journal* should fall into a narrow self-satisfied provincialism. Seeking these sometimes-conflicting objectives, while providing the Association with satisfactory house-organ coverage of our organizational business, has demanded much of their time and their thought. The Committee heartily commends them.

Advisory Committee To The Editor
Blaine Lewis, M.D., Louisvile
Andrew Moore, M.D., Lexington
Willett H. Rush, M.D., Frankfort
Orson P. Smith, M.D., Louisville
George F. Brockman, M.D., Greenville
Chairman

STATISTICAL SUMMARY
GROSS INCOME—JOURNAL KSMA

Year	Income	Year	Income
1952-53	$11,350.08	1958	$38,505.35
1953-54	13,574.42	1959	45,108.94
1954-55	15,843.28	1960	48,994.55
1955-56	20,200.86	1961	38,124.68
1956-57	26,998.72	1962	30,089.62
		1963	25,733.16

COMPARATIVE ADVERTISING COSTS

One page, black-and-white, single insertion

	Cost/page	Circulation	Cost/1000
Modern Medicine	960		
Medical Economics	1,095		
JAMA	1,465	187,719	$ 8.90
State Medical Journals	2,011	127,090	15.00

Recommendations, KSMA Board of Trustees

The Board of Trustees reviewed this report on

August 8, 1963. The report, including all recommendations, was approved without dissent.

Recommendations, Reference Committee No. 6

Reference Committee Number 6 recommends acceptance of this report.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the Professional Relations Committee

The Committee on Professional Relations has had no grievances referred to it during the 1962-63 associational year.

It is understood that those grievances that were not disposed of at the district level were acted on by the Board of Trustees of KSMA.

Professional Relations Committee

G. L. Simpson, M.D., Greenville
Irvin Abell, Jr., M.D., Louisville
Robert W. Robertson, M.D., Paducah
E. B. Mersch, M.D., Covington
Richard R. Slucher, M.D., Buechel, Chairman

Recommendations, KSMA Board of Trustees

The board of Trustees reviewed this report on August 8, 1963. The report was accepted as presented.

Recommendations, Reference Committee No. 6

Reference Committee Number 6 recommends acceptance of this report.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the KSMA Committee on Third Party Medicine

The Third Party Committee had a joint meeting with KSMA's Hospital Committee in Lexington on November 8, 1962 soon after word was received that the United Mine Workers Association was closing certain UMW hospitals in eastern Kentucky. Others present at the meeting were representatives from county medical societies in eastern Kentucky, State Health Department, U of K Medical Center, Kentucky Hospital Association, UMW and officials and staff of the Kentucky State Medical Association. The purpose of the meeting was to get information which might be available for the Committee's use in dealing with this particular third party problem.

Your chairman, along with the chairman of the Hospital Committee, attended a two day meeting in Harlan January 10-11 at which time top officials of the same organizations were represented. It was apparent by this date that the corporate practice of medicine was on its way out in eastern Kentucky so far as UMWA is concerned. This subject has since become a matter with which the KSMA Hospital Committee should work.

Even though the Third Party Committee has been relatively inactive during the past year, it is recommended that this Committee be continued and stand ready for any third party problems which may arise.

Committee on Third Party Medicine

Walter L. Boswell, M.D., Lexington
Ballard Cassady, M.D., Pikeville
Robert Jasper, M.D., Somerset
Robert E. Norsworthy, M.D., Hartford
John S. Harter, M.D., Louisville, Chairman

Recommendations, KSMA Board of Trustees

The Board of Trustees reviewed this report on August 8, 1963. The report, including all recommendations, was approved without dissent.

Recommendations, Reference Committee No. 6

Reference Committee Number 6 recommends acceptance of this report and of the recommendation that this committee be continued.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the Committee to Study the Constitution and Bylaws*

The Bylaws Committee met May 22 in an afternoon-long session in the headquarters office. We were glad to welcome KSMA President, David M. Cox, M.D., and the Association's Legal Counsel, Mr. E. Gaines Davis, Jr.

The Board of Trustees recommendations on this report will be listed at the conelusion of it for the benefit of the House of Delegates.

The Committee observed that several state medical associations had recently removed the word "state" from their official title. It was also noted that the Kentucky Dental Association had removed the word "state" from its title at its last meeting.

Advantages for doing this were listed as follows: avoid having the public confuse the medical association with state government, and the shorter title would allow for brevity and efficieney. Inasmuch as the word "state" is a part of the official title in the Constitution, to remove it would cause the Constitution to be changed as well as the Bylaws meaning that it would be necessary to give a year's notice.

After discussion the following motion was adopted: . . . "That a recommendation be made to the House of Delegates that in order to avoid confusion by lay people in thinking this is a part of state government the name of Kentucky State Medical Association be shortened to that of Kentucky Medical Association." It was understood that final action on this recommendation if accepted by this 1963 session of the House, could not be taken until 1964.

The Committee next studied the request for defining the duties of the KSMA Advisory Committees to the University of Kentucky and the University of Louisville. It was felt that Chapter VII, Section 13 of the Bylaws calling for the Council on Medical Education and Hospitals to "maintain active liaison with Kentucky's two medical schools" was not adequate. After discussion, the following motion was passed: "That the Committee to Study the Constitution and Bylaws recommends to the Board of Trustees that each council be asked within a reasonable length of time to study the work of their committees and outline the broad framework in which they are to operate and then report back to the Board of Trustees."

The next item considered by the Committee related to the matter of reports by trustee district grievance committees. It was felt that Chapter VI, Section 4 should be amended to adequately clarify and set up procedures in this area. The present Bylaws reads as follows:

> "Collectively the Board shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Board without discussion. It shall hear and decide all questions of discipline affeeting the conduct of members or a eomponent society upon which appeal is taken from the decision of

*The complete KSMA Bylaws as revised at the 1963 session of the House of Delegates starts on page 1175.

an individual Trustee or District Grievance Committee. In hearing appeals, the Board may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, efforts toward conciliation and compromise shall precede all such hearings. Its decision in all such cases shall be final."

After discussion the Committee voted to change Chapter VI, Section 4 to read as follows:

"Collectively the Board shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Board without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the Constitution, Bylaws, or rule or regulation of this Association, or the Principles of Ethics of the American Medical Association, shall be liable to censure, suspension or expulsion.

No disciplinary decision of an individual Trustee or District Grievance Committee shall become effective unless and until approved by the Board of Trustees, and where an appeal from such decision is taken by the respondent member, the Board may admit such oral or written evidence as in its judgment will best and most fairly present the facts.

It may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be heard on the record made before the component society, in the manner provided in Chapter XI, Section 10 of these Bylaws.

Efforts toward conciliation and compromise shall precede the hearing of disciplinary cases, but the decision of the Board of Trustees in all such cases shall be final."

A second change under this general subject related to Chapter XI, Section 6. The addition that the Committee voted to recommend is presented in script type: ". . . All members of component societies shall be members of the Kentucky State Medical Association, and shall be classified in accordance with Chapter I, Section 2 of these Bylaws. *Provided, however, that no physician who is under suspension or who has been expelled by the Board of Trustees shall thereafter, without reinstatement by said Board, be eligible for membership in any component society.* Any physician who desires to become a member of the Kentucky Medical Association . . ."

At the 1962 meeting of the House of Delegates it accepted a resolution presented by Campbell-Kenton County, which directed that "the House of Delegates institute a study of the apportionment of Trustees to the Kentucky State Medical Association with a view toward equal representation."

Following the 1962 meeting, the Executive Committee of the Board of Trustees asked this committee to make the study. During the lengthy discussion, it was pointed out that Jefferson County for example, has approximately one-third of the membership of the state association with only one trustee to represent it. The discussion also brought out that because of the location of the headquarters office, the office of the secretary of the Association is always located in Louisville, that Jefferson County always has either a President-Elect, President or immediate Past President, that it always has a Vice President and a Delegate to the AMA. (Also, an alternate delegate, who while he doesn't have voting privileges does have privileges of the floor). (It was also pointed out that most of the time, Jefferson County either has a Speaker or a Vice-Speaker of the House of Delegates.)

Thus it was indicated that Jefferson County has a minimum of five representatives on the Board of Trustees and in some years has more than five.

The following motion was then offered: "That the Committee recommend to the House that the State outside Jefferson County be re-districted into districts containing approximately 200 members and that each such district be allowed to elect one trustee, and that Jefferson County continue to comprise one district and elect one trustee."

The effect of this motion, it was pointed out, would be to reduce the number of trustee districts from fifteen to eight. This was felt desirable except it would increase the area to be visited by the trustees. If this recommendation were approved by the House, it was felt that the House might want to delete the obligation contained in Chapter VI, Section 3 of the Bylaws, which reads as follows: ". . . . He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the existing component societies and their members. . . ." It was observed that this requirement was being honored more in the breach than in the observance, anyway.

The Committee then passed a motion which made a recommendation to the House contingent upon the acceptance of the preceding motion. This recommendation reads as follows: "The unwritten law which requires that the three vice presidents come from the eastern, central and western parts of the state, and that the presidency rotate between these areas, should also be revised so that Jefferson County should comprise one area and the remainder of the state comprise the other two areas."

Finally, under this section, it was taken by consent that if the House of Delegates accepted both of the preceding motions, that it would be the responsibility of the Board of Trustees to implement these two actions.

Committee to Study the Constitution and Bylaws

Herbert Chaney, M.D., Dawson Springs
Marvin B. Dillon, M.D., Paris
Robert S. Dyer, M.D., Louisville
Bruce Hamilton, M.D., Shepherdsville
Douglas H. Jenkins, M.D., Richmond
Ernest C. Strode, M.D., Lexington, Chairman

Recommendations, KSMA Board of Trustees

The Board of Trustees reviewed this report on August 8, 1963.

The report was accepted as presented except for the section relating to the reapportionment of trustees. The Board voted to send this portion to the House without recommendation.

Recommendations, Reference Committee No. 6

(A) Reference Committee Number 6 recommends the acceptance of the recommendations as stated in paragraph 5, page 1. which will change Article I of the Constitution to be stated as follows: "Name of Association. The name and title of this organization shall be the Kentucky Medical Association."

Mr. Speaker, I move the adoption and implementation of this section of the report. (The motion was seconded and carried.)

Recommendations, Reference Committee No. 6

(B) Reference Committee Number 6 accepts the recommendations of the committee as listed in quotation marks in paragraph 1, page 2.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Recommendations, Reference Committee No. 6

(C) Reference Committee Number 6 accepts the amendment of Chapter VI, Section 4 as stated on pages 2 and 3.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Recommendations, Reference Committee No. 6

(D) Reference Committee Number 6 accepts the addition to Chapter XI, Section 6 as stated in script type in paragraph 4, page 3.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Recommendations, Reference Committee No. 6

(E) Reference Committee Number 6 disapproved the recommendations as stated in quotation marks in paragraph 3, page 4.

Other recommendations in paragraph 3, page 4, and the following paragraph were also disapproved because of the interrelations of the three recommendations.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the Interim Meeting Committee

Your committee met and was able to obtain five excellent speakers. Doctor Karl Jonas from Philadelphia gave an excellent informational discussion concerning Blue Shield.

Doctor Ever Curtis held the record attendance spell-bound for thirty minutes talking on our rapid progress down the road to socialism.

Doctor Milton Davis gave a most inspiring discussion of what AMPAC has done and what we can do to keep this worth-while effort going full speed.

Reverend William Slider helped our lunch digest by a humorous discussion of the serious nature of the centralization of power in our United States of America.

Mr. Burl St. Clair, one of our devoted allies, told what the Farm Bureau is attempting to do to stem the tide of government control.

KSMA Interim Meeting Committee
Wilbur Houston, M.D., Erlanger
Dexter Meyer, M.D., Covington
Mrs. James S. Rich, Lexington
Keith P. Smith, M.D., Corbin
David M. Cox, M.D., Louisville, Chairman

Recommendations, KSMA Board of Trustees

The Board of Trustees reviewed this report on August 8, 1963. The report was accepted as presented.

Recommendations, Reference Committee No. 6

Reference Committee Number 6 recommends the acceptance of this report.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and car-

Report of the Representative on the Kentucky Poison Control Program

No report submitted and therefore no action.

Report of the Secretary

(Page 6, Paragraph 2)

Before closing this report, I would like to make one recommendation to the House of Delegates. Except for the office of secretary and the office of treasurer, no officer of the association can be elected for more than two consecutive terms. I would propose that the Bylaws be amended to limit the term of secretary and the term of the treasurer to two three-year periods. This is in keeping with the policy of the Board of Trustees to bring in new leadership and keep the officers of the association as responsive as possible to the times and the will of the profession. In looking to the future, we would like to adjure you as members of the House to recall that there are elements within our society who are becoming increasingly active and bold in our national and state legislative halls who would change our free enterprise system and who would alter the practice of medicine as we know it today. To combat this, we must give an increasing amount of our resources, our effort and our time. We owe this to the people and to the generations of physicians to come.

Recommendations, Reference Committee No. 6

Reference Committee Number 6 disapproves of the recommendation "I would propose that the Bylaws be amended to limit the term of secretary and the term of the treasurer to two three-year periods."

It was felt by the entire committee that the present provisions in Chapter IV, Section 1 leaves the problem of the length of service of the secretary and the treasurer in consecutive terms to the vote of the House of Delegates, who would be in a position to limit a particular member in these offices to the number of terms that would serve its purposes. It is also noted that there is no provision in this section that prevents an individual in such offices from resigning or refusing re-election.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Special Report on Finances from the Board of Trustees to the House of Delegates

Our Association has reached a point in the development of its purposes at which it can no longer finance its expanding activities on its present income. To what degree this is serious and the reasons back of it need very clear elucidation. To do this best, perhaps we should first review our purposes. Permit me time then to read Article II of our Constitution. "The purpose of the Association shall be to federate and bring into compact organization the entire Medical Profession of the State of Kentucky and to unite with similar Associations in other states to form the American Medical Association with a view to the extension of medical knowledge; the advancement of medical science and charity;" (Did you know that word "charity" was in there?) "the evaluation of the standards of medical education; the enactment and the enforcement of just medical laws; the promotion of friendly intercourse among physicians in the guarding and fostering of their material interests;" (and surely we need not be ashamed of that) "the protection of the members thereof against unjust assaults upon their professional care, skill and integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of diseases and in prolonging and adding comfort to life."

There are contained here nine avenues of pursuit. Perhaps we should say ten because that word "charity" is not the least.

From its beginning this organization has not been one to let its purposes rest idly on paper. It has pursued its purposes with diligence. With the passage of time have come economical growth, economic and

social changes and political pressures that have brought great magnitude and complexity to our purposes. This has meant steadily increasing committee functions and headquarters staff activity and expense.

I believe it was in 1957 that the House of Delegates authorized an increase in dues to $50, principally because of a desire to be more active in fields of civic responsibility and postgraduate education.

In 1959, recognizing the near hopeless inadequacy of the 1200 square feet of office space which was your headquarters, you asked a Committee to investigate the feasibility of building and owning your own headquarters. This Committee did its work with great care and a year later the House of Delegates authorized the construction of its own headquarters building, without dissent.

This splendidly functional building has increased our headquarters working space over 400% at an increase in only 127% in maintenance cost including debt service. Any of you who have seen our headquarters staff at work realize that all of this space is well utilized.

Historically, final costs of building always exceed estimates, and of course ours did. It ended up at about $213,000 for the project as against the estimated cost of $150,000. In 1960 this gave us no real concern. We had closed that financial year $22,000 ahead and our experience in preceding years had been building up to that amount. We had a reserve fund of $137,000.

With or without that steady financial background, no one could have predicted what was going to happen to us financially in the next three years. Listen. While profit is not our purpose we actually had for the fiscal year ending June, 1960 a surplus of $22,000. In 1961 it was $7,000. By 1962 we had an operating deficit of $7,000. In 1963 we saw an operating deficit of $13,000. Our projected operating deficit for the financial year ending June 30, 1964 is $13,795. While interest on our mortgage is $4,000 of this figure, annual payment on debt retirement of $15,000 is not included.

Now what happened?

Consider first our income. It comes from dues, services that we render for others, from technical exhibitors fees at our meetings and from our Journal. Over the past three or four years it is of interest how fixed our income has been from dues. It runs $102,000 to $105,000. Income from services amounts to about $5,000 yearly.

The income from our Meeting almost precisely covers the Meeting expense from year to year. Loss on the Meeting commonly runs much less than $1,000. Thanks in no small part for this is the work of our Executive Secretary and his fine relationship with our technical exhibitors. This happy situation can be maintained by the personal interest of each of us in the technical exhibits. This year we might even make a couple of hundred dollars on the Meeting.

The astounding drop in income from our Journal, however, has been a circumstance that was totally unpredictable in 1960 and it is probably the straw that broke the camel's back.

Gross receipts from the Journal, which had risen steadily for seven years to an all time high of nearly $50,000 in 1960, then slipped rapidly from year to year to $25,000 in the year ending June 30, 1963. It is well stated in the report of the Editor's Advisory Committee, "In any commercial publication this would have been disastrous." Well, it has been disastrous for us too. In 1960 the surplus receipts from the Journal amounted to $5,000. In 1961 there was a net loss of $4,000. In 1962 a net loss of $11,000. In 1963 a net loss of $12,000. Projected hopefully for 1964 is a net loss of $11,000. All these mentioned amounts, of course, are in round numbers. The precise amounts are in the record. The difference between a $5,000 surplus (in 1960) and a $12,000 net loss (in 1963) is a loss per member of more than $8.00

The thing that brought about this stunning blow to the fortunes of the Journal must be reported here.

Eighty-eight percent of Journal income has been from national advertisers, predominantly the national ethical drug houses. With the Senate investigation of the drug industry and its stultifying affect on their research and the way they must advertise, drug manufacturers have reexamined their whole advertising policy. Since the Kefauver investigation, the Thalidomide controversy and the minutiae of subsequent directives from the Food and Drug Administration, it is perhaps understandable that the drug companies are diverting their advertising away from promotion of specific drug products more and more to foundations and scholarships. This is the thing of course that we could not possibly foresee in 1960.

Now let's take some similar survey of our expenses.

First of all, like many others on limited income, we have an ancient aunt for whose maintenance and doctor bills we are responsible. This is the McDowell House in Danville. Fortunately, this fine old lady has a little income of her own and also, fortunately, she has some other nephews who help out with her support. Notably the Kentucky Surgical Society and American College of Obstetrics and Gynecology. However, she costs *us* about $3,000 a year.

Monies which are spent are for things which you have approved or which you have directed to be done. Now it would be utterly foolish to say that we could not anticipate the same increasing costs of living for our Association that we experience in our personal expenditures, but on a fixed income there is not much we can do about it as an Association any more than anyone else on a fixed salary—not to mention a diminishing one.

Increases in salaries and fringe benefits for our fine headquarters staff were planned and have come, or are coming, into effect. This is necessary.

Implementation of more programs has been expressed in the general headquarters expense. More programs have meant more office supplies and more complicated office equipment. All of these very useful gadgets of course require maintenance.

The long-distance telephone has become increasingly necessary as a means of communication with the pressure of the times. We have all become aware of this. For our Association telephone budgeting has doubled since 1961. Then, of course, Uncle Sam has increased the cost of postage 25%. He appears to be in financial difficulty too. All of these individually minor items only add up to a manifestation of our times.

The pressure of government for control of the whole field of health, including our profession, with all that implies in depressing the quality of the services we can give, of the crushing affect on ourselves of making our profession a business instead of a service and in dimming further the American dream of personal freedom, we must recognize as our greatest concern and we must expect to do so increasingly in the future. There must be added to this the increasing amount of legislation in the field of health at both the federal and state levels. In this we must maintain an active interest.

Legislative activities three years ago were budgeted at $1,500 by your Association. Last year it was $3,000. For the present year, which is to be a State legislative one, the amount is doubled to $6,000. Other groups opposing us in the field of legislative activity laugh at us in disbelief of these small figures. Yet nothing has paid off better for us than our efforts in the field of legislation, as recent history has recorded. This field we must assume as one of never ending struggle and our activities here must be expected to expand. If it has fallen upon the medical profession to be the spearhead of the defense of personal freedom in America, then we must not fail.

These are in outline the facts back of our increasing deficits of the past two years—the sharp and severe fall in Journal income due to government action in the field of drugs, the need for our increasing activities and their inevitably increasing cost in these inflationary times.

To contend with these facts of life your budget committees have from year to year considered in detail each big and little expense and, where it could reasonably be done and still keep the expenditures within your wishes, they have eliminated. The Board of Trustees has cut down on programs where they were not worth the expenditures and has held back elsewhere monies they would like to have spent.

On recommendation of Board of Trustees to House of Delegates you withdrew from the postgraduate education program except for the clerical work involved when it became evident that attendance at the programs did not warrant $6,000 of what was spent.

Regretfully, we have advised our alternate delegates that their expenses to the American Medical Association meetings cannot be paid, as alternates.

Also with deep regret, the Board has held its support of our magnificent Women's Auxiliary to $500. This is a pitiful amount, after all they have done for us in recent years.

Newsletters will no longer go out to you from two sources monthly, but from one source on a PRN basis. This is a much more sensible arrangement, both in matters of time and labor and in effectiveness, as well as in money saving. Other small items have been eliminated where possible.

Other programs that you have ordered or that looked very desirable have had to be held in abeyance.

KEMPAC Educational Fund, with a donation from us that would pay for a secretary, could positively expand its income from outside sources to a tremendous degree.

Your authorized program to publicize the facts about cults is ready to go. It has to wait.

In spite of these things, the cold fact remains that in order to carry out our program we have had to draw heavily on our reserves in the past two years. Last year it was $32,500. At the end of the current fiscal year as budgeted our reserves will be *gone*. (Incidentally, we have had good financial advice that an association of this type should maintain a fluid reserve ahead for one full year).

We know now that the things we will want to do in the future will increase and without doubt will increase in cost. But if an organization is to remain alive it cannot regress, nor can it stand still. Its activities and its services must expand. This is inevitable.

With these circumstances, and most pressingly the fact that we must withdraw from even present well-conceived programs with the end of the current fiscal year in June, 1964 on our present income, the Board of Trustees recommends to this House of Delegates an increase in dues of active members of $25 a year to be effective in January, 1964.

It may be of some interest to us that of the fifty states and the District of Columbia, the general average of dues is $62. Twenty-eight have dues that are greater than ours and their average is $77. Of all the states, forty have either raised their dues in the past three years or are planning to do so.

At the best possible projection, considering our present rate of expenditure only and allowing for no new programs and for no contingencies such as happened to our Journal, it will take us three years to restore our reserves to a proper figure with this income. However, allowing our reserve to accumulate more slowly, we *can* progress with our needed programs by continuing to watch our expenditures very closely.

Gentlemen, the Board of Trustees commends to you your due consideration of the above matters. They are immediately pressing. The future conservation and progress of medicine in Kentucky rests with you.

This is your obligation and we hope you will see it as your privilege.

Recommendations, Reference Committee No. 6

Reference Committee Number 6 after listening to much discussion and giving the matter deliberate thought, voted to unanimously recommend to the House of Delegates an increase in dues of active members of $25 a year to be effective in January 1964, as recommended in the report in paragraph 2, page 7.

This committee feels that the alternative to such an increase is to be found in the area of curtailment of present obligations and entrance into new obligations in the future which under our Constitution we are pledged to carry out. This alternative was not one that we could recommend.

Mr. Speaker, I move the adoption and implementation of this section of the report. (The motion was seconded and carried.)

Resolution E

Campbell-Kenton County Medical Society

WHEREAS pertinent discussion has been of a limited nature on controversial issues at the Delegates meetings and

WHEREAS it appears that the reticence is frequently a fear of distortion of remarks by an unfavorable partisan press corps and

WHEREAS the problems of this society should be fully aired to reach the best possible solutions, Therefore be it

Resolved, that future meetings of the House of Delegates of the KSMA be held in executive session.

Recommendations, Reference Committee No. 6

Reference Committee Number 6 disapproves this resolution on the basis that any session of the House of Delegates may elect at any given time to go into executive session if its purposes are to be better served by doing so.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Resolution K

Campbell-Kenton County Medical Society

WHEREAS, many trustee districts are distant from Louisville requiring much travel, and

WHEREAS, all districts wish to be represented at all Trustee Meetings, and

WHEREAS, the conscientious trustee will usually be a busy practitioner and will have conflicts even though he very much desires to attend the Trustee Meetings,

THEREFORE, be it resolved that the House of Delegates in the future elect an alternate trustee for each trustee district.

Recommendations, Reference Committee No. 6

Reference Committee Number 6 disapproves this resolution.

Mr. Speaker, I move the adoption of this section of the repoert. (The motion was seconded and carried.)

Mr. Speaker, I move acceptance of this report as a whole. (The motion was seconded and carried.)

Reference Committee No. 6

M. Randolph Gilliam, M.D., Lexington, Chairman
John D. Allen, Jr., M.D., Louisville
Harry J. Cowherd, M.D., Frankfort
Richard E. Davis, M.D., Central City
J. Sankey Williams, M.D., Nicholasville

REFERENCE COMMITTEE NO. 7

Hollis Johnson, M.D., Chairman
Miscellaneous Reports

Report of the KSMA Representative to Conference of Presidents and Other Officers of State Medical Associations

Capacity attendance in the American Room of the Traymore Hotel, Atlantic City was called to order by President George M. Fister. He introduced the President-Elect, J. Lafe Ludwig who talked too long but gave much valuable information and statistics concerning our rapid centralization of power and our loss of freedom.

The next speaker was Lea H. Irwin who told us about the operation of the House Ways and Means Committee.

Then Walter Petravage, Manager of Public Affairs Department U. S. Chamber of Commerce, gave an excellent talk on Competition for Survival.

Honorable Donald C. Bruce, Representative from Indiana gave a most enthusiastic twenty minute talk entitled "Planners, Plots, and Plunderers." He told of ruthless activities of the present executive member of our Government as is common with those who are invested with too much authority.

The last speaker, Dr. Nicholas Nyaradi, A Hungarian refugee, was a dynamic personality who told us that "it can happen here," meaning the same thing that happened in Hungary.

David M. Cox, M.D., President
Kentucky State Medical Association

Recommendations, Reference Committee No. 7

Reference Committee No. 7 recommends that this report be accepted and that Doctor David Cox be complimented by the House of Delegates for his efforts in attending the Conferences of Presidents and Other Officers of State Medical Associations.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of KSMA Representative, U. of K. Chapter, Student AMA

Your KSMA representative to SAMA at University of Kentucky has been pretty much standing in the wings as the chapter organizes. They have been quite active on a national and local level and have apparently not deemed it necessary to call on their representative in recent months.

Richard H. Segnitz, M.D., Lexington
KSMA Representative
University of Kentucky Chapter
Student AMA

Recommendations, Reference Committee No. 7

Reference Committee No. 7 recommends that this report be accepted. We also recommend that the KSMA Representative, University of Kentucky Chapter, Student AMA, become more active in his efforts to work with the students at the University of Kentucky School of Medicine.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of KSMA Representative, U. of L. Chapter, Student AMA

The following is a report of last year's activities.

Several meetings were held with SAMA. The revision of the Constitution and By-Laws has made administrative effect considerably better. They have had a specific project of improving the General Hospital medical hospital library, and this is under way.

The boys have been vitally interested in this year's national legislative picture, and information as to pending legislation.

Our group at the National SAMA Convention in Chicago voted in opposition to federal loan funds to medical students. The National Delegation, however, voted in support of this pending bill. This was one of the items of discussion in Atlantic City at the AMA Legislative Council, and is resulting in steps over the city to bring local and State Societies in closer contact with medical students and medical schools.

Some of our boys still have two or three years remaining in school which indicates that they may hold high national office if they continue to display the same enthusiastic efforts.

It is again good to report that the relationship between the SAMA of the University of Louisville and the University of Kentucky is most cordial and warm.

All in all, it has been a very good year and one from which we can take courage to the future that we will soon have these bright young men active with us in organized medicine.

Hoyt D. Gardner, M.D., Louisville
Representative
U. of L. Chapter, Student AMA

Recommendations, Reference Committee No. 7

Reference Committee No. 7 recommends that this report be accepted and that Doctor Hoyt Gardner's activity and interest in his work with the students at the University of Louisville merits the commendation of the House of Delegates.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the McDowell Home Committee

This committee has had three luncheon meetings at which the following have been discussed with decisions reached:

1. We expressed in letters signed by each of us our thanks and appreciation to Mrs. Walker Owens of Mt. Vernon and Mrs. James Rich of Lexington for the careful and time-consuming inventory they made of the items in the Home. This was published by the Woman's Auxiliary in an attractive illustrated brochure with cover design by Mrs. Irving Gail of Lexington.
2. The Committee has received several letters praising the restoration and complimenting our hostess, Miss Crawford, on her gracious reception. Mr. Thomas McCaskey, Vice-President of Colonial Williamsburg, came to Kentucky to advise in the restoration of Shaker Village near Harrodsburg. He was delighted with "the McDowell restoration" and said that it was credible from top to bottom without a false note.
3. Two letters recently came to us and are now hanging in the Home: one by Dr. McDowell to his son-in-law (1815), and one by Mrs. McDowell to her sister. These were given to us by Mr. William Scott of New York in memory of his mother, Mrs. Katherine Shelby Scott, who was a great-granddaughter of Dr. McDowell. Two books of the McDowell Library were given by the Reverend Barton of Accomac, Virginia through the alert influence of Otto Brantigan, M.D., of Baltimore. Doctor Brantigan hopes to get for us more of this library. One of the members of this committee has been assured that Pfizer and Company has recently purchased one of only two special "pill tiles" in this country and will give it to the McDowell Apothecary Shop. The other tile is in the Smithsonian Insti-

tute. The tile was bought by Mr. Blumberg, a collector, and sold to Pfizer and Company on condition that this company would give it to the McDowell Apothecary Shop after a suitable period for display in Pfizer's collection.

4. On June 24th the 5th Division of the American College of OB-GYN held an all-day meeting at the McDowell Home at the invitation of one of our committee members, Laman A. Gray, M.D. This group has given the Home $250 a year for the past two or three years. The Committee approves the use of the Home by this and other surgical and medical societies.
5. The finances of the Home and Apothecary Shop are in sound condition to July 1, 1963. A complete audit is available.
6. The Committee unanimously disapproves the suggestion that the McDowell Home and Apothecary Shop be returned to the Kentucky State Park Commission, for these reasons:
   A. We, representing the KSMA, have made a promise to our donors that we would maintain the property. In the past thirteen years gifts have amounted to nearly $70,000 above the KSMA annual stipend and admission fees. We believe that asking the State Park Commission to "take over" would be a breach of trust to these donors.
   B. We believe that the property will be better maintained under the personal interest of this committe than it will be under the State. It was the personal interest of three (Abel, McCormick, Vance) that started this project. It has been the personal interest of the KSMA McDowell Home Committee that has kept it at the present level. We understand why the KSMA budget committee must cut costs because of important loss of revenue but we do not think it wise to cut the appropriation here or to turn over to the State one of our best loved and best kept heritages. Such a change would save each of us from 50 cents to a dollar a *year!* Each of the items received this past year, for example: books, letters, apothecary shop equipment, money; were given because of the *personal* interest and time to some member of this committee. Thanks to this personal time and interest, the McDowell Home and Apothecary Shop are known all over the United States.
7. Some years ago the KSMA appointed three laymen to this committee. Their contributions have been valuable. One has been the main influence in raising $38,000 from the pharmacists of Kentucky and pharmaceutical houses for the restoration of the Apothecary Shop; another has spent many hours labelling and filling the shop bottles with drugs and dried herbs of that period (1790-1830); and the third, a resident of Danville, has been local curator of the property. The last has recently been elected president of a national society of pharmacists.
8. The Trustees voted at the June meeting to approve the efforts of this committee to continue working with the officers and citizens of Danville to clear 2nd Street opposite the Home and to make this side of the street a part of adjacent Constitution Square. The Councillors were assured that this project would not be any expense to the KSMA.

McDowell Home Committee
Robert Bateman, M.D., Danville
Rankin C. Blount, M.D., Lexington
Mr. Sterling Coke, Lexington
Laman A. Gray, M.D., Louisville
Mr. George Grider, Danville
E. M. Howard, M.D., Harlan
Dean Earl P. Slone, Lexington
David Kinnaird, M.D., Louisville
Co-Chairman
Francis Massie, M.D., Lexington
Chairman

Recommendations, Reference Committee No. 7

Reference Committee No. 7 felt that the report of the McDowell Home Committee was an excellent one. The House of Delegates commended this Committee on its active interest in the McDowell Home Project. We felt that the Committee should continue to make every effort toward obtaining outside financial support. Reference Committee No. 7 recommends that the KSMA continue its financial support of this worthy project.

Mr. Speaker, I move the adoption of this report. (The motion was seconded and carried.)

Report of the Building Committee

With the occupation of the Headquarters Building by the Association in January 1962, the Building Committee had essentially discharged the responsibilities which you had delegated. At the last meeting of the House, the Building Committee was continued for the present year, to observe the completion of all contract details, and to formally advise the discharge of the contractor at the conclusion of the contract period.

A meeting was held on January 17, 1963, attended by all members of the Committee, the Architectural Advisor, the Contractor, and some sub-contractors. A detailed inspection was made, and minor corrections secured. The contract was formally concluded on January 26, 1963.

It was the opinion of the Committee that both the architect and the contractor had given unusual service and quality of performance. We advised the Board of Trustees of this, and, in the name of the Association, the Board formally extended our thanks and recognition for the quality of performance of these artisans.

With all building activities completed, we advise the discharge of this Committee.

N. L. Bosworth, M.D.
Hoyt Gardner, M.D.
George F. Brockman, M.D., Chairman

Recommendations, Reference Committee No. 7

Reference Committee No. 7 recommends that the report of the Building Committee be accepted. They have completed their work. Reference Committee No. 7 recommends that the House of Delegates commend this Committee for its dedicated work.

Mr. Speaker, I move the adoption and implementation of this report. (The motion was seconded and carried.)

Report of the KSMA Representative, Advisory Committee on Maternal and Child Health, State Department of Health

The Maternal and Child Health Advisory Committee meeting was held in Louisville on December 12, 1962. Your KSMA representative was present. Attendance was poor due to inclement weather throughout the state. Doctor Helen B. Fraser, Director of the Division of MCH, Kentucky State Department of Health, conducted the meeting.

Primary attention was devoted to improving Pediatric care in rural Kentucky. A progress report on the four pediatric clinics which have been established in Eastern Kentucky under the direction of the U. of K. Medical Center was given. The clinics are held at three month intervals in each location, i.e., one clinic

monthly in one of the four locations, and are staffed by four pediatricians, a social worker and a laboratory technician from the University of Kentucky Center and a laboratory technician from the State Department of Health laboratory. It is hoped that similar clinics in Western Kentucky can be established under the direction of the U. of L. Medical Center. Doctor Frank Falkner, new Chief of the Department of Pediatrics at U. of L. voiced his willingness to establish such clinics if adequate personnel could be obtained to man them.

The appalling need for specialized facilities for the care of prematures and diagnostic and treatment facilities for Rh babies was also discussed. On the scene establishment of such facilities would be economically unfeasible and illogical because of inadequate specialized nursing personnel. Consideration was given to the possible use of helicopter ambulances or mobile nursery vans to handle such emergencies and transport them to larger centers. Further discussion of this will be developed at future meetings. All in all, the third meeting of this committee was a very fruitful one.

William C. Durham, M.D., Louisville
KSMA Representative

Recommendations, Reference Committee No. 7

Reference Committee No. 7 reviewed this report. There was considerable discussion about the advisability of helicopter and mobile ambulance service in the care of prenatal and Rh babies. The Committee, however, feels that every effort should be made to improve pediatric care in rural areas where the need for this has been demonstrated.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the KSMA Memorials Commission

The Commission met on May 29 at the KSMA Headquarters Office. We were pleased to have President David M. Cox meet with us. There was a full discussion covering areas of activity that were open to the commission. Four recommendations were drafted for consideration by the KSMA Board of Trustees. They are:

1. That members of the Board of Trustees of KSMA be given an opportunity to purchase a chair (at a cost of $75 per chair) in the Board Room and that those who were serving on the Board at the time the new building was being constructed also be given the opportunity, with the understanding that an appropriate plaque bearing the name of the donor would be placed on the back of the chair.

2. It was recommended to the KSMA Board of Trustees that the living ex-presidents of the Association and the wives of deceased past presidents be asked to contribute $100 each to the furnishings of the President's Office and any necessary purchases of the miniature museum in the President's Office. Permanent recognition of these gifts would be accomplished by an appropriately inscribed plaque on the wall.

3. Attention was called to successful plans for life membership now in operation in the American College of Physicians, and the Southern Medical Association. As a means of easing the present strain on the Association's budget, it was recommended that the KSMA Board of Trustees appoint a committee to study, develop and recommend that an actuarially sound live membership plan for consideration to be put in operation by the Association.

4. Advantages in activating the miniature museum in the President's Office were held to be obvious. It was recommended that appropriate insertions in The Journal of KSMA and in the Association's News Letters be placed, urging the membership to make suitable contributions of instruments and equipment used by the profession during the early years in the life of our state.

The Chairman of the Commission appeared before the Board of Trustees at its June 6 meeting and presented the Commission's recommendations. All were accepted by the Board, which is greatly appreciated by the Commission. While it is not to be expected that full implementation of these recommendations for voluntary contributions will remove the present budgetary problems, it is felt that they would make an important contribution.

KSMA Memorials Commission
G. Y. Graves, M.D., Bowling Green
Francis Massie, M.D., Lexington
Carlisle Morse, M.D., Louisville
J. Duffy Hancock, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 7

Reference Committee No. 7 wishes to compliment the KSMA Memorials Commission on its excellent report. The Committee feels that an opportunity for memorial contributions to the KSMA should be extended to the entire membership, past and present.

Mr. Speaker, I move the adoption and implementation of this report. (The motion was seconded and carried.)

Mr. Speaker, I move the adoption of this report as a whole. (The motion was seconded and carried.)

Reference Committee No. 7
Hollis Johnson, M.D., Louisville, Chairman
Harold B. Barton, M.D., Corbin
L. F. Beasley, M.D., Franklin
Norma T. Shepherd, M.D., Hopkinsville
Joseph H. Saunders, M.D., Lexington

Unfinished Business

It was stated that there was no unfinished business at this time. The Speaker expressed appreciation for the spirit of cooperation and good will of the delegates.

Election of Officers

The Speaker then called for the report of the Nominating Committee which was presented by Carl Fortune, M.D., Lexington. Doctor Fortune read the following list of nominations for the positions to be filled which were as follows:

President-Elect	Delmas M. Clardy, M.D., Hopkinsville
Vive-Presidents	
Central	Carlisle Morse, M. D., Louisville
Eastern	Carl C. Cooper, Jr. M.D., Bedford
Western	John Dickinson, M.D., Glasgow
Secretary	Henry B. Asman, M.D., Louisville
Treasurer	Keith P. Smith, M.D., Corbin
AMA Delegate	John C. Quertermous, M.D., Murray
AMA Alternate Delegate	William W. Hall, M.D., Owensboro
AMA Delegate	Wyatt Norvell, M.D., New Castle
AMA Alternate Delegate	Charles C. Rutledge, M.D., Hazard
AMA Delegate	J. Thomas Giannini, M.D., Louisville
AMA Alternate Delegate	Charles G. Bryant, M.D., Louisville

After each nomination was presented, the Speaker called for nominations from the floor but none were made and each nominee was elected individually without dissent.

Doctor Fortune then submitted the following nominations to the office of trustee:

Fifth District	Alfred O. Miller, M.D., Louisville
Sixth District	Rex Hayes, M.D., Glasgow
Seventh District	Donald Chatham, M.D., Shelbyville
Eighth District	W. Donald Janney, M.D., Covington
Eleventh District	Hubert C. Jones, M.D., Berea
Fifteenth District	Robert Pennington, M.D., London

The same procedure followed in electing the general officers was followed in the election of the trustees, and there being no nominations from the floor, the above-named nominees were elected.

The new President-Elect, Doctor Clardy, was escorted to the rostrum. Following a standing ovation, Doctor Clardy made brief remarks.

Nominations for Board of Directors, Kentucky Physicians Mutual, Inc.

The following list of nominees for the Board of Directors, Kentucky Physicians Mutual, Inc., was submitted at this time and received for information only:

Rankin Blount, M.D., Lexington
John Dickinson, M.D., Glasgow
Carl Fortune, M.D., Lexington
Thomas Gilbert, M.D., Bowling Green
John D. Gordinier, M.D., Louisville
William W. Hall, M.D., Owensboro
J. Duffy Hancock, M.D., Louisville
Charles Hugan, M.D., Covington
Coleman C. Johnston, M.D., Lexington
Thomas O. Meredith, M.D., Harrodsburg
Wyatt Norvell, M.D., New Castle
George Pedigo, M.D., Louisville
Mr. Hasty Riddle, Louisville
Richard Rust, M.D., Newport
Mr. J. E. Stanford, Louisville
Mr. J. P. Sanford, Louisville
Garnett J. Sweeney, M.D., Liberty

Election of 1964 Nominating Committee

The nominating committee to serve at the 1964 Annual Meeting was duly elected as follows:

C. Melvin Bernhard, M.D., Louisville
N. L. Bosworth, M.D., Lexington
Richard E. Davis, M.D., Central City
Paul F. Maddox, M.D., Campton
J. Sankey Williams, M.D., Nicholasville

George P. Archer, M.D., prestonsburg, was installed as president by the Chairman of the Board of Trustees, Keith P. Smith, M.D., Corbin, who administered the oath of office.

The new president's first official act was that of presenting the past president's key to the retiring president, David M. Cox, M.D., Louisville.

Doctor Sweeney thanked the members of the House of Delegates for their attentiveness during both sessions. There being no further business, a motion was made, seconded and carried that the 1963 meeting of the House of Delegates adjourn.

Additions and Corrections Made to "Murder by Design"

Horace E. Campbell, M.D., Denver, Colorado, whose special article, "Murder by Design," appeared in the August issue, has asked us to include some of the material which space considerations led us to delete.

He wishes to point out that the proposed legislation which he suggested is not a new, radical approach, but is legislation soundly based on the American legislative tradition (i.e., the Meat Inspection Act, the Pure Food and Drug Act, the Civil Aeronautics Act, the Marine Safety Act, the various Railway Safety Acts, and the recent Refrigerator Door Act).

The following deleted material is to be inserted near the middle of column two of page 670, after the paragraph, "It is the opinion of this observer . . ."

"Railway safety legislation beginning in 1893 took the form of federal laws with detailed technical specifications, i.e., size of bolts, strength of handholds, etc. (10). In today's fast-moving technology this approach is not recommended for the motorcar. Aviation history presents a far better precedent.

In 1911 it became obvious that aviation was progressing much more rapidly in other countries than that in which it was born. When World War I erupted in 1914, it was reported that France had 1,400 airplanes, Germany 1,000, Russia 800, Great Britain 400, and the United States 23. (6)

On March 3, 1915, the National Advisory Committee for Aeronautics was established with a budget of $5,000. It was effective preparation for World War II, but too late for the war in progress. No American airplane fired a shot or dropped a bomb in anger in World War I. The American aces flew French or British planes.

The Committee consisted of twelve of the outstanding scientists in the United States, six of the twelve being members of the National Academy of Sciences. Under its guidance and the rational coordination of research which it sponsored, aviation made excellent progress. Under its successor, the National Aeronautics and Space Administration, our rocket program is competitive."

The final paragraph of his article should read, "It is my opinion, belonging to the Patrick Henry school, that we must solve the traffic death and injury problem just the way that we solved our previous serious health problems. The recent thalidomide affair should have some lessons for us in traffic safety."

Tom F. Whayne, M.D., has been named assistant vice president of the University of Kentucky Medical Center and dean of the College of Medicine. Doctor Whayne, a 1931 graduate of the Washington University School of Medicine in St. Louis, served in the U.S. Army for 22 years, retiring with the rank of Colonel in 1955. Prior to coming to Lexington he was assistant dean of the School of Medicine at the University of Pennsylvania.

ORGANIZATION SECTION

KSMA Interim Meeting Set For Jenny Wiley Park April 23

KSMA members are urged by George P. Archer, M.D., KSMA president, to reserve the date of Thursday, April 23 to attend the 1964 KSMA 14th annual Interim Meeting to be held at Jenny Wiley State Park near Prestonsburg.

"The program committee for the Interim Meeting has put together a very strong and most interesting program which we believe will be one of the best ever presented," Doctor Archer said.

The president pointed out that the beautiful new mountain parkway between Winchester and Prestonsburg is completed except for nine miles, thus making the location of the meeting easily accessible.

KSMA Members were urged to watch The Journal of KSMA and the KSMA Communicator for more information on this second most important Association-sponsored meeting.

Dr. Simpson Testifies On Kerr-Mills in Kentucky

Gaithel L. Simpson, M.D., Greenville, former KSMA president, represented KSMA before the House Ways and Means Committee with testimony opposing the King-Anderson proposal (H.R. 3920) during the hearings of the Committee November 21 in Washington.

Kentucky's indigent medical care program has been criticized nationally as an example of why Kerr-Mills is not adequate to meet the health needs of those citizens over 65 years of age. Doctor Simpson used the seven minutes allotted him to point out that Kentucky's program is not too limited in benefits or too rigid in eligibility requirements. He also showed that it was very efficient in terms of administrative costs.

Kentucky was one of ten states allowed to testify during the committee hearings on Medical Care for the Aged from November 18 to 27.

Six Ky. ACS Fellows Named

Six Kentucky surgeons were admitted to Fellowship in the American College of Surgeons at the October 31 initiation ceremonies held during the ACS Annual Meeting in San Francisco.

Elected to full membership were Harold J. Kosasky, M.D., William H. Marshall, M.D., Kenneth H. McCrocklin, M.D., Louis S. Sonne, M.D., and Norton G. Waterman, M.D., all of Louisville, and Thomas J. Huth, M.D., Newport.

George P. Archer, M.D., Prestonsburg, KSMA president, is pictured taking the oath of office as a member of the Kentucky State Board of Health from Governor Bert T. Combs. Doctor Archer was appointed to the Board to replace E. M. Howard, M.D., who retired October 22.

Dr. Archer Named a Member of State Board of Health

George P. Archer, M.D., Prestonsburg, KSMA president, was named October 23 by Governor Bert T. Combs as a member of the State Board of Health, replacing E. M. Howard, M.D., Harlan, who retired October 22.

In addition to holding many offices in organized medicine, Doctor Archer was appointed by Governor Combs in 1960 to the White House Committee on Aging, and was named a member of the Kentucky Hospital Council in 1962.

A chairman of the Floyd County Board of Health since 1954 and presently the Mayor of Prestonsburg, Doctor Archer received the KSMA Distinguished Service Award in 1961.

Combs Recipient of Award

The Honorable Bert T. Combs, former Governor of Kentucky, was one of six recipients of the second annual International Awards of the Joseph P. Kennedy, Jr. Foundation, for their outstanding efforts in the field of mental retardation. The presentations were made at a dinner at the Americana Hotel in New York on December 4.

Governor Combs was recognized for his leadership in organizing programs in Kentucky to help the mentally retarded. He was also cited for his consistent work with professional leaders in the field of mental retardation and his encouragement of community leaders to take local action.

Local Political Seminars Sponsored by KEMPAC

County medical societies are being asked to hold seminars on political action by the Kentucky Educational Medical Political Action Committee (KEMPAC) according to its chairman, Hoyt D. Gardner, M.D., Louisville.

Endorsement was given the project by the KSMA Board of Trustees recently when Harold B. Barton, M.D., Corbin, representing the KEMPAC Board of Directors, presented the idea and asked for approval.

A substantial number of the county societies have made arrangements to present such a seminar, and the KEMPAC Board is urging full cooperation of all the societies. Doctor Gardner said that smaller counties might either combine with other small counties, or with larger counties if deemed advisable, to hold such seminars.

Kentuckians to Participate in Southern Surgical Meeting

Several Kentucky physicians will take part in the scientific program of the Southern Surgical Society at its Annual Meeting being held December 10-12 at the Homestead in Hot Springs, Va.

Participants and their topics are: McHenry S. Brewer, M.D., clinical instructor in surgery at the University of Louisville—"Pyloric Exclusion with Excision of the Gastric Mucosa, (Bancroft-Plenk Procedure": Ben Eiseman, M.D., professor and chairman of the department of Surgery at the University of Kentucky—"Surgery of the Narcotic Addict"; Laman A. Gray, M.D., associate clinical professor of ostetrics and gynecology and Malcolm L. Barnes, M.D., associate clinical professor of pathology, both at U. of L., "Histogenesis of Adenocarcinoma of the Endometrium"; and James B. Holloway, M.D., Lexington—"Definitive Surgery for Malignant Lymphoma."

Surgeon General of the Army Leonard Heaton, a native Louisvillian and a graduate of the U. of L. Medical School, with I. S. Ravdin, M.D., professor of surgery at the University of Pennsylvania, will present a paper entitled, "President Eisenhower's Operation for Regional Enteritis, A Footnote to History."

Dr. Minish Quits Journal Post

The resignation of Lawrence T. Minish, M.D., Louisville, who has been Case Discussions editor of The Journal for the past five or six years, was accepted with regret by the KSMA Executive Committee at their October 31 meeting. The committee expressed deep appreciation for Doctor Minish's excellent service.

Oscar J. Hayes, M.D., Louisville, who has served as secretary of the case discussion group since the department was initiated about ten years ago, was elected to replace Doctor Minish. Members of the Executive Committee expressed the view that the Case Discussions section was one of the most useful features of The Journal.

American College of Surgeons Names Dr. Noer to Office

Rudolf J. Noer, M.D., Louisville, was named first vice president-elect of the American College of Surgeons at the 49th clinical congress of the ACS held October 28-November 1 in San Francisco.

Doctor Noer, who is professor and chairman of the department of surgery at the University of Louisville School of Medicine, was also installed the previous week as president of the American association for Surgery of Trauma at the meeting of the association in San Francisco. The group has about 440 surgeon members who have special interest in the treatment of injuries and wounds.

A 1927 graduate of the University of Pennsylvania Medical School, Doctor Noer is a member of the KSMA Advisory Committee to the University of Louisville.

Dr. Keller New President of Automotive Medicine Assn.

William K. Keller, M.D., professor of psychiatry at the University of Louisville and a member of the KSMA Highway Safety Committee, was elected president of the American Association of Automotive Medicine, which met early in November in Los Angeles.

Arthur H. Keeney, M.D., assistant professor of ophthalmology at U. of L. and chairman of the KSMA committee, was elected secretary of the association.

The nine-year-old association is made up of more than 300 physicians, plus a number of associate members who are interested in automobile safety. The group will hold its 1964 meeting in Louisville October 26-27.

KAGP Seminar Set Jan. 16

The Northern Kentucky Seminar of the Kentucky Academy of General Practice will be held January 16 in Cincinnati, according to information released by Robert E. Smith, M.D., Covington, program chairman. The day-long session will be held at the Sheraton-Gibson Hotel. A meeting of the Board of Directors of the KAGP will be held the evening of January 15.

Cancer Society Elects

John C. Weeter, M.D., Louisville plastic surgeon, has been elected president of the Kentucky chapter of the American Cancer Society. Ralph M. Scott, M.D., Louisville, and David W. Kinnaird, M.D., Louisville, were named vice-presidents.

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SUBMIT DATES OF PG MEETINGS

From now to the end of the year, many medical organizations are selecting dates for next year's meetings. Some are already selecting topics and speakers and planning programs.

The Continuing Medical Education Office of KSMA would like to urge these societies and organizations to notify this office of the dates and topics, so they can be added to the "Continuing Educational Opportunities" page in The Journal. In this manner we hope to avoid conflicts in dates and to inform a large audience of these up-coming meetings.

You are urged to submit this information to the KSMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville 5, Ky.

In Kentucky

DECEMBER

12 Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.

19 Annual Postgraduate Seminar, Norton Memorial Infirmary, Louisville, Ky.

19 University Surgery Day, University of Kentucky, Lexington, Ky.

27 Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

JANUARY

9 Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.

15 Cancer Teaching Lecture Series, University of Kentucky, Lexington, Ky.

16 University Surgery Day, University of Kentucky, Lexington, Ky.

16 Northern Kentucky Seminar, Kentucky Academy of General Practice, Cincinnati, Ohio.

23 Hypertension Seminar, St. Joseph Infirmary, Louisville, Ky.

24 Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

FEBRUARY

6 Thursday Night Psychiatry Seminar, University of Kentucky, Lexington, Ky.

13 Thursday Night Psychiatry Seminar, University of Kentucky, Lexington, Ky.

13 Montly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.

13-15 Rheumatic Diseases, University of Kentucky, Lexington, Ky.

19 Cancer Teaching Lecture Series, University of Kentucky, Lexington, Ky.

20 Thursday Night Psychiatry Seminar, University of Kentucky, Lexington, Ky.

20 University Surgery Day, University of Kentucky, Lexington, Ky.

20 Contributions of Modern Pharmacology to Rational Clinic Use of Drugs, University of Kentucky, Lexington, Ky.

27 Thursday Night Psychiatry Seminar, University of Kentucky, Lexington, Ky.

28 Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

Surrounding States

DECEMBER

10-12 Southern Surgical Association, Hot Springs, Va.

11 Pediatrics, Indiana University, Indianapolis, Ind.

12 Pediatric Cardiology, Indiana University, Indianapolis, Ind.

JANUARY

5-8 The Cardiovascular System, 1st Annual Postgraduate Seminar in Anesthesiology, University of Miami and University of Florida, Miami, Fla.

8-9 Treatment of Pulmonary Disease, Indiana University, Indianapolis, Ind.

13-17 Vaginal Endocrine Cytology, Ohio State University, Columbus, Ohio.

22-23 Dermatology, Indiana University, Indianapolis, Ind.

27-29 American College of Surgeons, Baltimore, Md.

E. M. Howard, M.D., at left in front, holds the citation presented to him by Governor Bert T. Combs October 22 in recognition of 35 years as president of the State Board of Health. Pictured with Doctor Howard following the presentation ceremony are: C. C. Howard, M.D., Glasgow, seated at right, and from left, standing, Sam A. Overstreet, M.D., Louisville, Governor Combs, Carl H. Fortune, M.D., Lexington, and Russell E. Teague, M.D., Frankfort, Commissioner of Health in Kentucky.

Dr. E. M. Howard Honored For Service to State

E. M. Howard, M.D., Harlan, 1942 president of KSMA, was honored October 22 in Frankfort at ceremonies commemorating his retirement after 35 years of service with the State Board of Health.

Governor Bert T. Combs presented Doctor Howard with a citation "in recognition of distinguished service on behalf of all the people of the commonwealth." Sam A. Overstreet, M.D., Louisville, gave a plaque to Doctor Howard on behalf of the KSMA, and Carl H. Fortune, M.D., Lexington, presented a silver tray from the Board of Health. Both Doctors Fortune and Overstreet are members of the Board.

Doctor Howard, who was president of the Board for all but a few months of his service, has practiced in Harlan County since his graduation from the University of Louisville School of Medicine in 1908.

A Fellow of the American College of Surgeons, Doctor Howard holds memberships in many other organized medical groups and has been active in business and civic affairs.

Donald Chatham, M.D., Shelbyville, general practitioner and a member of the KSMA Board of Trustees, was recently elected to a second two-year term as president of the Georgetown College Alumni Association.

Ky. Given Immunization Grant

Kentucky is one of 25 recipients of Public Health Service grants totalling $3.4 million issued to 18 state and 7 city-county health departments to assist in community immunization campaigns against polio, diphtheria, tetanus, and whooping cough, according to United States Surgeon General Luther L. Terry.

George P. Archer, M.D., KSMA president, recently announced the appointment of Delmas M. Clardy, M.D., KSMA president-elect, Hopkinsville; Robert B. Warfield, M.D., Lexington, and J. Sankey Williams, M.D., Nicholasville, to serve on the state Immunization Advisory Committee. Additional committee members will be chosen from other organized medical groups to serve on this committee, Russell E. Teague, M.D., Commissioner of Health, said.

Dr. Perera Supports Eye Research

Charles A. Perara, M.D., New York, guest speaker of the Kentucky EEN&T Society at the 1963 Annual Meeting, donated his check from KSMA to cover his expenses and honorarium to the National Council to Combat Blindness, Inc., with the request that it be sent to "C. Dwight Townes, M.D., in Louisville for his new eye research laboratories." The National Council to Combat Blindness supports ophthalmologic fellowships and research projects.

NAME

ADDRESS

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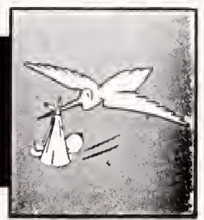

CASE #106 A 19-year-old, single, Negro primigravida consulted a physician in the third month of pregnancy. She was referred to a maternity home out of the state, where she delivered a living infant under spinal anesthesia on March 6, 1961. She was discharged on March 13, 1961, and returned to her home. Two days after her return, she noted a vague feeling of illness, consisting of a headache and a sensation of weakness in her legs and difficulty in walking, together with generalized aching and fever.

On March 30, 1961, the day of admission, she had a convulsion described as a grand mal seizure. Her chief complaint was weakness, a stiff neck, vomiting, and mental depression. The past history was negative for toxemia or hypertension. There was a history of someone in her recent environment who had active tuberculosis.

On admission, the patient was a slender, very seriously ill Negro female with depressed sensorium. She responded to questions rationally but slowly. Her neck was very stiff, and her skin and mucous membranes were pale. The pupils were dilated, and reacted very poorly to light. A circular nystagmus rendered the funduscopic examination difficult, but there seemed to be papilledema of the right disk. The tongue protruded in the midline and the uvula elevated in the midline. There was no facial paralysis, and the patient had a good girp bilaterally. She was unable to lift the left foot from the bed, and was able to lift the right one only with difficulty. There appeared to be some atrophy of the calf muscles bilaterally. All deep reflexes were present and active. A chest x-ray and serologic test for syphilis were negative. The blood count showed mild anemia; no organisms were found in smears of the spinal fluid. The spinal fluid pressure was elevated to 240 mm H_2O, and the fluid contained 400 white cells per cubic millimeter.

A consultant suggested a diagnosis of tuberculous meningitis and myelitis secondary to spinal anesthesia, together with acute postpartum depression psychosis.

The patient continued to have episodes of convulsive phenomena in the hospital in spite of anti-convulsive therapy with Sodium butisol and Dilantin. On the second hospital day, she was able to sit on the side of the bed and appeared normal. On the fifth day, she started a gradual downhill course and at 9:50 P.M. on April 5, she had a severe convulsion, went into a coma and expired.

The final diagnosis was meningitis of unknown etiology, and anemia due to chronic blood loss. Autopsy was requested but refused.

Comments

This committee considered this to be an example of a direct obstetrical death with possible preventable factors. The out of state delivery made it difficult to obtain more specific information. The ideal anesthetic has not yet been found, but since 1947, the incidence of meningitis following spinal anesthesia has been very low. Dripps (JAMA 156:1486,1954) found none in a series of 10,098 cases, while Sadove (Canad Anaesth, Soc. J. 8:405,1961) found 8 cases, in a series of 20,000 patients. In Sadove's series, cultures of spinal fluid showed no growth. These reports indicate that meningitis, aseptic or bacterial, following spinal anesthesia may have an approximate incidence of 1 in 10,-000. Despite a small but real hazard, spinal anesthesia is peculiarly well suited to the practice of obstetrics, if for no other reason than that it is administered by a physician who is able to assist if an emergency should arise.

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numbs the pain...not the patient

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3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient")*.

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Two Groups Hear Dr. Gardner Speak on Medicare Bill

Hoyt D. Gardner, M.D., Louisville, chairman of the Kentucky Educational Medical Political Action Committee (KEMPAC) presented the negative viewpoint during a debate on Medicare before the Fall Board Meeting of the Kentucky Junior Chamber of Commerce in Frankfort November 10.

Opposing Doctor Gardner was Caldwell B. Esselstyne, M.D., Director of the Rip Van Winkle Clinic in New York and chairman of the Physicians' Committee for Health Care of the Aged through Social Security.

On the evening of November 2 Doctor Gardner spoke at the Indiana Conference on Public Affairs, sponsored by Indiana University at Bloomington, before the Indiana High School debating teams and their coaches.

Doctor Gardner discussed the disadvantages that would accrue to the enactment of the current King-Anderson Bill pending before Congress. The pros and cons of this legislation is the subject for high-school debating teams across the country.

Dr. Griswold Gets Safety Award

R. Arnold Griswold, M.D., Louisville surgeon, was the recipient of the National Safety Council's 1963 Surgeon's Award for distinguished service to safety, presented at a meeting of the committee on trauma of the American College of Surgeons in San Francisco October 28.

The award was presented in recognition of Doctor Griswold's work in promoting the use of automobile seat belts. He is a former chairman of the committee and is currently a member of the KSMA Highway Safety Committee.

Former AMA President Dies

Harrison H. Shoulders, Sr., M.D., Nashville, Tenn. surgeon, died November 17 in Nashville following a heart attack. Doctor Shoulders, 77, was president of the American Medical Association in 1946-47. He was also a charter member of the American Board of Surgeons. Doctor Shoulders retired from active practice in 1955.

S.E. Surgical Congress to Meet

The 1964 meeting of the Southeastern Surgical Congress will be held on the S.S. Hanseatic from March 21-28, according to J. Duffy Hancock, M.D., Louisville, Councilor from Kentucky. The ship will leave from Port Everglades, Florida, will make stops at St. Thomas, San Juan, and Nassau, and will return to Port Everglades on March 28. For further information write to A. H. Letton, M.D., secretary-director, 340 Boulevard, N.E., Atlanta 12, Ga. R. Arnold Griswold, M.D., is first vice president of the Congress, which has 185 members in Kentucky.

Dr. J. B. Lukins Retires From Blue Shield Board

Joshua B. Lukins, M.D., Louisville surgeon, has retired from practice and as an active member of the Board of Directors of Kentucky Physicians' Mutual, Inc. (Blue Shield).

In their November 7 meeting the Board of Directors went on record as being deeply grateful for Doctor Lukins' long and loyal service to the Board and the physicians and people of Kentucky.

Doctor Lukins, 1935 president of the Kentucky State Medical Association, is a charter member of the Board of Directors of Kentucky Physicians' Mutual. He has also served as a KSMA Delegate to the AMA, as a member of the AMA Judicial Council, and was for more than 20 years chairman of the KSMA Medico-Legal Committee.

Dr. Annis Denounces Lawsuit Of Steelworkers' Official

In response to requests for comment on the lawsuit filed by Paul Normile against the American Medical Association recently, Edward R. Annis, M.D., president of the AMA, made the following statement:

"This is a ridiculous lawsuit which is improperly directed, a transparent publicity stunt, and a smoke screen to divert attention from the hearings currently being conducted by the House Ways and Means Committee on the administration's government health care bill.

"The American Medical Association will give its reply in court. The reckless charge of fraud leveled at the AMA by George Meany is completely false."

The lawsuit was brought by Normile, a Pittsburgh steelworkers' official, who claims that a record distributed by the American Medical Political Action Committee (AMPAC) is a forgery and constitutes violation of privacy and libel. The record concerns alleged forcible solicitation of funds from union workers for the purpose of aiding passage of the King-Anderson Bill.

Secretaries of M.D.s, Note— KSMA Communicator

The "KSMA Communicator," the new and official newsletter of your state association, was distributed to all KSMA members Friday, November 15. The "Communicator," which replaces the "Secretary's Letter" and "Newscapsules," will be issued on an "as needed" basis rather than follow any pre-determined schedule.

Since the "Communicator" will be sent to you as a "self-nailer," rather than enclosed in an envelope, you are urged to request that your secretary be especially watchful for the first few issues until she has become familiar with the new format.

This new publication is designed to bring the latest information on KSMA activities, legislative development, and other pertinent matters to KSMA members.

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News Items

Daniel G. Lareau, M.D., Owensboro, has announced the opening of his office in that city for the practice of internal medicine. Doctor Lareau, a 1952 graduate of the University of Vermont School of Medicine, completed his residency at DeGoesbriand Memorial Hospital in Burlington, Vt. Until recently an assistant professor of medicine at the University of Kentucky College of Medicine, Doctor Lareau was previously in private practice in Henderson.

Jesse F. Minnis, Jr., M.D., has joined the staff of St. Joseph Infirmary in Louisville for the practice of thoracic surgery. A 1948 graduate of New York Medical College, Doctor Minnis interned at Methodist Hospital in Brooklyn. He was a resident at the same hospital, and completed his residency requirements at King's County Hospital in Brooklyn in 1956. Before coming to Kentucky, Doctor Minnis was in private practice in Brooklyn.

Jack D. Amis, M.D., recently opened an office in Hopkinsville for the practice of general surgery. A 1956 graduate of the University of Louisville School of Medicine, Doctor Amis interned at Detroit Receiving Hospital and was engaged in general practice at Williamson, W. Va. for two years before completing his residency in surgery in 1963.

Jerry D. Fraim, M.D., has become associated with **Paul B. Hall, M.D.** at Paintsville, for the general practice of medicine. Doctor Fraim, a 1962 graduate of the University of Tennessee School of Medicine, is a native of Weeksbury, Ky. He completed his internship at the Methodist Hospital in Memphis.

Dan Stamper, Jr., M.D., has recently entered the practice of general medicine in Pikeville in association with **William F. Clarke, M.D.** Doctor Stamper graduated in 1962 from the University of Tennessee School of Medicine, and completed his internship at Cabell Huntington Hospital in Huntington, W. Va.

William E. Bakewell, Jr., M.D., psychiatrist, has joined the staff of the University of Kentucky Medical Center, it was announced recently. Doctor Bakewell, who received his M.D. from McGill University in 1949, is a native of Evansville, Ind. Following his internship at the U.S. Naval Hospital in Newport, R.I., he was a resident in general surgery at the Denver Veterans Administration hospital. He completed his residency in psychiatry at the University of North Carolina.

Paul A. Pichardo, M.D., has taken over his duties as medical director of the District Six State Tuberculosis Hospital at Glasgow, succeeding A. G. Lewis, Jr., M.D. Doctor Pichardo, a 1945 graduate of the University of Mexico Medical School, completed his residency at Huipulco TB Hospital in Mexico City. He has been assistant director of the District Six hospital for the past year.

Steve H. Bowen, M.D., has entered the practice of general medicine at Paintsville, where he is associated with **E. G. Skaggs, M.D.,** and **A. B. Carter, M.D.** Doctor Bowen, a 1946 graduate of the University of Louisville School of Medicine, interned at St. Elizabeth Hospital in Covington and served as a Lieutenant Commander in the U. S. Navy for two years. He has previously practiced in Fleming, Ky., Norton and Coeburn, Va., and Harlan, Ky.

Warren W. Babcock, Jr., M.D., has become associated with **John H. Hemmer, M.D.,** in Louisville, where he will limit his practice to general and vascular surgery. A 1956 graduate of the University of Michigan School of Medicine, his internship and residency requirements were fulfilled at the University of Michigan Hospitals.

Kenneth L. Lockwood, MD., has joined the staff of the Covington Tuberculosis Sanitorium. Doctor Lockwood, who retired this year after practicing with the Veterans Administration since 1929, is a 1920 graduate of the University of Cincinnati College of Medicine. He interned at Booth Memorial Hospital in Covington and served his residency in internal medicine at Henry Ford Hospital in Detroit.

James M. Chase, Jr., M.D., has become associated with **John M. Allen, M.D.,** in Lexington, where he will limit his practice to general surgery. A former chief of surgery at Castle Air Force Base Hospital at Atwater, Calif., Doctor Chase is a 1956 graduate of the University of Maryland School of Medicine. He interned at Delaware Hospital in Wilmington, Del., for one year prior to becoming a resident at the University Hospital in Baltimore.

Joseph Hamburg, M.D., has joined the staff of the University of Kentucky College of Medicine as a full-time assistant professor of medicine. A general practitioner, Doctor Hamburg graduated in 1951 from Hahnemann Medical College in Philadelphia. Doctor Hamburg was previously in private practice in Stamford, Conn.

Leonard B. Berman, M.D., is now affiliated with the University of Louisville with offices in Louisville General Hospital. Doctor Berman, who limits his practice to internal medicine (renal diseases), is a 1947 graduate of New York University College of Medicine. A native of Boston, he interned at Boston City Hospital, and was a resident at Boston City Hospital, the U. S. Naval Hospital, St. Albans, W. Va., and Georgetown Hospital.

Walter R. Morris, M.D,, has begun the practice of ophthalmology in Louisville, according to a recent announcement. A 1955 graduate of the University of Louisville School of Medicine, Doctor Morris interned at Louisville General Hospital before completing his residency at Indiana University. After completing his internship, he practiced general medicine in Breckinridge County.

Governor Bert T. Combs addressed the luncheon session of the Kentucky Rural Health Conference held October 21 at Jenny Wiley State Park near Prestonsburg. Pictured at the luncheon are William Paden of the Kentucky Farm Bureau Federation and secretary of the Kentucky Rural Health Council; Governor Combs; James C. Salato, M.D. Columbia, chairman of the Kentucky Rural Health Council; and Charles Dickson of the University of Kentucky Agriculture Extension Service and conference program chairman.

MILK DRINKERS—Kentucky's lovely Dairy Princess, Miss Jane Harrison of Farmington, is pictured serving glasses of milk to Rural Health Conference participants William Paden, left, secretary of the Kentucky Rural Health Council; Edmond Yantes, M.D., Wilmington, Ohio, a member of the AMA Rural Health Council; and Donald Graves, M.D., Frenchburg, chairman of the KSMA Rural Health Committee.

Ky. M.D.s Participate in Meeting

Three Louisville physicians took part in the affairs of the House of Delegates of the American Society of Anesthesiologists at the November 2-6 meeting at the Palmer House in Chicago.

L. S. Weakley, M.D., was a delegate to the House. W. N. Bennett, M.D., served as alternate delegate, and Robert W. Lykins, M.D. served as director.

To pay for their medical education, thousands of students, interns and residents are applying for bank loans guaranteed by the AMA-ERF student loan program. Your donation to AMA-ERF's Loan Guarantee Fund can help provide top quality medical care for America's future generations. Mail your contribution to 535 North Dearborn Street, Chicago 10, Illinois.

Medical School News

$7,000 in Gifts and Grants Accepted by U. of L.

Gifts and grants totaling $7,000 were recently accepted by the University of Louisville Board of Trustees on behalf of the School of Medicine.

$5,000 in an unrestricted gift to the Medical School was presented by the Smith Kline and French Foundation. The Gheens Foundation gave $1,000 as an unrestricted gift that will be applied toward construction costs of the Child Psychiatry Study Center. A grant of $1,000 was accepted from Mead Johnson and Company for a study of the effects on tissue transplanted in animals under the direction of Giovanni Raccuglia, M.D.

Faculty Appointments and Changes

In recent actions by the Board of trustees of the University of Louisville George W. Pedigo, M.D., Louisville, was promoted to associate clinical professor of medicine, and Cecil Wendell Shafer, M.D., was appointed associate professor of anesthesiology.

John F. Taylor, Ph.D., was granted a leave of absence from March to September to accept a National Science Foundation Grant to do research on Hemoglobin at the University of Rome. The Board approved the resignations of Bruce M. Anderson, Ph.D., as assistant professor of biochemistry; Charles G. Gussler, M.D., instructor in ophthalmology; Warren Dennis, Ph.D., assistant professor and research director, department of ophthalmology; and Giovanni Corcella, M.D., instructor in psychiatry.

A grant of $1,000 to help establish a residency program in dermatology in the School of Medicine from Westwood Pharmaceutical Company was accepted by the board.

The following additional changes have been made in the faculty at U. of L:

Appointments: Kareem Minhas, M.D., associate professor, and Dorothy Shipe, M.D., instructor, both in the department of pediatrics; Charles Byrne Severs, M.D., clinical instructor in community health; Pietro M. Poletti, M.D., clinical instructor in psychiatry; Jesse F. Minnis, M.D., clinical instructor in surgery; and Alan J. McCartney, M.D., and Donald H. Mosley, M.D., both clinical instructors in medicine.

Charles R. Huffman, M.D., and Robert L. Woodard, M.D., were promoted to clinical assistant professors of orthopedic surgery.

U. of K. Announces New Faculty Appointments

The University of Kentucky College of Medicine has announced the appointment of two full-time and seven voluntary faculty members.

James C. Baxter, Ph.D., newly appointed assistant professor in the department of psychiatry, received his doctorate from the University of Texas. He has served on the summer teaching faculty of Duke University.

Robert M. Izard, Jr., M.D., instructor in the department of medicine, recently completed a residency in physical medicine and rehabilitation at Baylor University, where he received his M.D.

The following appointments have been made to the voluntary staff: Harry J. Batts, M.D., and Charles W. Nelson, M.D., instructors, department of clinical radiology; Aaron S. Mason, M.D., associate professor, and Conrad R. Williams, M.D., instructor, department of clinical psychiatry; John J. Loughrin, M.D., assistant professor in the department of clinical pathology; and Charles N. Tarkington, M.D. and James Bascome Stith, M.D., instructors, department of clinical obstetrics and gynecology.

County Society Reports

McCracken

Benjamin F. Rush, Jr., M.D., associate professor of surgery at the University of Kentucky College of Medicine, presented a very interesting scientific program on "Chemotherapy of Malignancies," illustrated by a color film and lantern slides, at the September 18 meeting of the McCracken County Medical Society at Boswell's Restaurant in Paducah.

During the business session a discussion was held regarding the raising of the state membership dues. B. E. Mutchler, M.D., and G. M. Shifley, M.D., were unanimously approved for membership in the county society.

The scientific program of the October 23 meeting, held at Boswell's Restaurant, was presented by J. Vernon Pace, M.D., Paducah. "Carcinoma of the Ovary," a film sponsored by the American College of Surgeons, was shown. During the business session, a motion was passed that the president appoint a nominating committee of three to select candidates for new officers to be elected at the December annual meeting of the McCracken County Society.

Rev. Paul B. McCleave, L.L.D., center, director of the AMA Department of Medicine and Religion, is show in discussion with William L. Woolfolk, M.D., Owensboro, left, chairman of the KSMA Committee on Medicine and Religion, and Harold Keen, M.D., Bowling Green, a member of the KSMA Committee, at the October 21 meeting of the Jefferson County Medical Society, Doctor McCleave was the featured speaker at the program on Medicine and Religion.

Checking their Respresentative districts on a map at the Medical Arts Building at the October 21 meeting of the Jefferson County Medical Society are, from left, Robert W. Lykins, M.D., David M. Cox, M.D., immediate past president of KSMA, Robert C. Long, M.D., and Louis Foltz, M.D., president of the Jefferson County Society. All are from Louisville. At the right is Rev. Samuel P. Diehl, pastor of St. John's Lutheran Church in Louisville, who is indicating his own district on the map. Several Jefferson County ministers attended the program Medicine and Religion, that evening.

Cleveland Clinic Course

"Colorectal Surgery in Children and Adults" will be the theme of the Cleveland Clinic Educational Foundation's postgraduate course to be presented January 8-9, 1964. For further information and application forms, contact: Education Secretary, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio, 44106.

William J. Martin, M.D., Louisville proctologist, has announced his retirement from practice. **Walter Thompson, M.D.,** has taken over Doctor Martin's practice at his former office in the Heyburn Building.

THE INSURANCE PAGE

The Health Insurance Council Claim Forms

MORE than ten years ago, our Kentucky State Medical Association supported a resolution in the AMA House of Delegates, urging simplification and standardization of the large number of claim forms used in the administration of health insurance benefits by voluntary prepayment organizations.

Preliminary studies by the Health Insurance Council (representing most of the larger private insurance companies) and by the AMA Council on Medical Service through its Committee on Insurance and Prepayment, revealed that as recently as 1951, insurance companies were utilizing 26 ways to ask for diagnoses; 34 ways to inquire about physical condition; 36 ways to inquire about treatment; 42 ways to ask about prognosis, and 18 ways to determine the insured's identity.

Through joint and prolonged effort of the Health Insurance Council and of the AMA Committee on Insurance and Prepayment Plans, six forms were developed and approved, which represented a vast improvement in simplification and standardization, over the multitude of previous forms.

More recently the H.I.C. and the AMA Committee have developed an "all purpose" form designated as "Attending Physicians' Statement Combined 1." This has been done to satisfy those physicians and societies expressing a desire to become familiar with and complete only one type of claim form for private health insurance carriers.

It is this form which has recently been approved officially by the Kentucky State Medical Association. Many, if not most of the other state medical societies have expressed similar approval of the form.

Due to the differences in the terms of their contracts (as opposed to the commercial carriers), most Blue Shield organizations, including our own Kentucky Physicians' Mutual, utilize shorter and less detailed claim forms, since less information is required to process their claims.

Occasionally, we hear objections voiced by our physicians to the Standard H.I.C. Combined 1 Form, on the ground that it is too detailed and too time consuming. Granted, none of us wishes to devote more time than is absolutely necessary to completing claim forms for our patients. We must also realize, however, that certain basic infomation must be available to the insuring organization before it can process any caim.

It would be fiscally irresponsible for any such organization to pay every claim, upon the request of the insured, without first verifying the nature and duration of the illness; the treatment rendered, and the eligibility of the subscriber to receive payment, under the terms of his contract. To do otherwise would be to penalize all other subscribers, since to allow abuse of the pooled funds by payment of unjustified claims would either result in cancellation of all such contracts, or a burdensome increase in the premium rates of all subscribers.

In those cases where the insurance company submits a claim form which is simpler and less detailed than the Combined 1 Form, it is quite permissible to utilize the shorter form of the Company, in preference to the H.I.C. Form. Conversely, if the H.I.C. Combined 1 Form is found to be shorter, less ambiguous, or more acceptable than the form submitted by any given company, the physician has the backing and sanction of the KSMA if he elects to fill out the standard form and return it in lieu of the company's own form. Such may not, in every instance, preclude the company from requesting additional and more specific information from the physician, before final settlement of the claim is effected.

The AMA House of Delegates has supported its Council on Medical Service in requesting

that the various county and state medical societies not attempt to develop their own forms. Such action could well result in a situation worse than that which existed several years ago.

The AMA Committee on Insurance and Prepayment, and the Health Insurance Council, both recognize that the instruments which have been developed are not perfect, and expect that future changes may eventually be effected to improve the desirability and acceptability of these forms.

W. Vinson Pierce, M.D.

News Notes

John D. Gordinier, M.D., Louisville, was re-elected secretary-treasurer of District V of the American College of Obstetricians and Gynecologists at the Annual District meeting in Detroit October 24. Charles F. Gillespie, M.D., Indianapolis, Ind., was named new chairman of the group.

Hermann K. Schueler, M.D., has joined the Trover Clinic in Madisonville, where he will limit his practice to urology. Doctor Schueler, who received his M.D. in 1948 from Phillips University, Marburg, Prussia, interned at Overlook Hospital, Summit, N.J., and completed his residency at Massachusetts General Hospital, Boston. He was formerly in practice in Harlan.

Keene M. Hill, Jr., M.D., has located in Horse Cave for the general practice of medicine, it was recently announced. Doctor Hill, a native of Burkesville, graduated from the University of Tennessee School of Medicine in 1962, and interned at St. Joseph's Hospital in Memphis.

Norton H. Bare, M.D., has announced the opening of his offices in Greenup for the practice of general medicine. A 1925 graduate of the University of Nebraska School of Medicine at Omaha, Doctor Bare has previously practiced in several other states and in China and Tibet.

Robert B. Matheny, M.D., has entered general practice at Sebree in association with **J. A. Logan, III, M.D.** A native of Stanford, Doctor Matheny is a 1962 graduate of Tulane University School of Medicine. He interned at Travis Air Force Hospital before entering practice in Sebree.

Cecil W. Shafer, M.D., has joined the staff of the department of anesthesiology at the University of Louisville School of Medicine. A native of West Virginia, Doctor Shafer graduated in 1934 from the University of Louisville School of Medicine. He was most recently associated with the University of Arkansas Medical Center.

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Associate Director

Walter S. Coe, M.D., Louisville, associate editor of The Journal of KSMA, is shown here moderating a panel at the national conference for State Medical Journal editors held late in October in Chicago. Next to Doctor Coe are: George H. Yeager, M.D., editor of the Maryland State Medical Journal; R. H. Kampmeier, M.D., editor of the Tennessee State Medical Journal; and A. Henry Clagett, Jr., M.D., editor of the Delaware State Medical Journal.

Ky. Physicians Present Paper

Herbert E. Brizel, M.D., and Ralph M. Scott, M.D., both of the radiology department of the University of Louisville School of Medicine, presented a paper on 'Further Studies in Relationships in Hodgkin's Disease" at the annual meeting of the Radiological Society of North America in Chicago November 17-22.

Indiana May Get New Med School

Francis Land, M.D., Fort Wayne, president of his Allen County Medical Society, has announced the appointment of a committee of 11 physicians to study the possibility of bringing a state-supported medical school to Fort Wayne.

Managing editor of the Journal of KSMA, J. P. Sanford, Louisville, second from right, was elected to a five-year term on the Advisory Committee to the State Medical Journal Advertising Bureau at the recent national conference for State Medical Journal editors. Other members of the committee and their respective Journals, are, from left, Frank B. Ramsey, M.D., Indiana, chairman of the committee; Perry R. Ayres, M.D., Ohio Journal; Edgar Woody, Jr., M.D., Georgia and Thad Moseley, M.D., Florida. Doctor Moseley was elected to fill out the term of the late Wingate Johnson, M.D. Sanford served as chairman of the 1963 biannual conference.

KSMA Council and Committee Reports

KSMA Board of Trustees Executive Committee

Douglas E. Scott, M.D., Lexington, Chairman

KSMA Headquarters Office — **October 31, 1963**

In a day-long session the Executive Committee handled many routine affairs including matters relating to the AMA House of Delegates, the 1964 Annual Meeting, setting the dates for future Annual Meetings, and the replacement of appointees on the 1963-64 KSMA committees who could not serve.

In addition, the committee considered matters relating to the Appalachian Regional Hospitals, Inc. The report of the Committee on Third Party Medicine was heard and matters relating to the 1964 meeting of the General Assembly were acted upon.

Much time was devoted to the implementation of the actions on the reports and resolutions submitted to the 1963 KSMA House of Delegates meeting in Lexington.

Council On Scientific Assembly

George P. Archer, M.D., Prestonsburg, Chairman

Kentucky Hotel — **October 16, 1963**

The Council reviewed the results of the 1963 meeting and attention was called to the fact that the 1964 Annual Meeting dates had been changed to September 29, 30 and October 1.

The Council set the over-all policies for the 1964 meeting and visited the new Convention Center where the 1964 meeting will be held to inspect the facilities.

It was learned that because the dates of the meeting were changed, it would not be possible to have color television for the 1964 meeting.

Scientific Program Committee

Douglas M. Haynes, M.D., Louisville, Chairman

KSMA Headquarters Office — **November 6, 1963**

General policies as set for the 1964 scientific pro-

gram by the Council on Scientific Assembly were reviewed by the committee.

Considerable attention was given to the development of the broad outline for the scientific program after President George P. Archer, M.D., expressed his desire for a highly profitable program.

Consideration was given to the possibility of having a Trans-Atlantic CPC and it was learned that the Smith Kline and French Laboratories would undertake to sponsor such a program.

Mental Health Committee

Frank M. Gaines, M.D., Louisville, Chairman
KSMA Headquarters Office **October 24, 1963**

The KSMA Mental Health Committee held its first meeting of this associational year and devoted considerable time to making preparatory arrangements for a Kentucky Congress on Mental Health tentatively planned to be held in Louisville during May, 1964.

The Committee discussed its new Sub-Committee on Alcoholism and also announced that 13 half-hour programs on Mental Health had been made available to radio stations throughout the United States.

The Committee requested that county medical societies appoint Mental Health committees so that information concerning mental health can be more readily accessible to the local physician.

Interim Meeting Program Committee

George P. Archer, M.D., Prestonsburg, Chairman
Jenny Wiley State Park **November 14, 1963**

The committee first gave attention to the arrangements for the 1964 Interim Meeting, which will be held at the Jenny Wiley State Park Thursday, April 23. Facilities to be used were inspected.

Arrangements for promoting the program were decided upon after full consideration. It was voted that emphasis for this meeting should be on the national legislation.

Long and careful consideration was given to speakers that would make the presentations and tentative selections were made. The President of the Woman's Auxiliary to KSMA along with the local county society secretary and the alternate delegate to the AMA of Eastern Kentucky were guests of the committee at this meeting.

Second Edition Released

The second edition of *Vaginal Hysterectomy*, by Laman A. Gray, M.D., professor of obstetrics and gynecology at the University of Louisville school of Medicine, was released October 10 by Charles C. Thomas, Publisher, of Springfield, Ill. The completely rewritten and enlarged edition is edited by E. C. Hamblen, M.D., professor of endocrinology and associate professor of obstetrics and gynecology at Duke University Medical Center, Durham, North Carolina.

Anes. Seminar Set Jan. 5-8

The First Annual Postgraduate Seminar in Anesthesiology has been set for January 5-8 at the Eden Roc Hotel in Miami Beach. The seminar, entitled, "The Cardiovascular System", is sponsored by the University of Miami and the University of Florida schools of Medicine. The course has been approved for 13 hours of Category 1 credit by the American Academy of General Practice. For further information contact Jerome H. Modell, M.D., University of Miami School of Medicine, Jackson Memorial Hospital, Miami 36, Fla.

W. B. SAUNDERS COMPANY features the following new books in their full page advertisement appearing elsewhere in this issue:

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The Lead Industries Association, Inc., New York, recently sent to the KSMA Headquarters Office a letter concerning two recent newspaper items which noted that "70% of deaths due to poison in the pre-school age group are caused by lead poison." In repudiation of this statement, the letter cites the following report from the U.S. Department of Health, Education, and Welfare, Division of Accident Prevention: 'In 1960 (the last year recorded), 445 deaths due to accidental poisoning involving children under five years of age are recorded. Seventy-eight of these, or 17.5%, are attributed to lead and its compounds. Over the ten-year period covered in this report, the percentage figure stands at 12.5%.'

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In Memoriam

LAMAR W. NEBLETT M.D.
Louisville, Ky.
1890-1963

Lamar W. Neblett, M.D., 73, Louisville surgeon, died October 24 at St. Anthony Hospital in Louisville. A 1913 graduate of the Medical Department of the University of Louisville, Doctor Neblett accepted a faculty appointment at the school after completing his internship at General Hospital. He retired in 1962 as associate professor of surgery. Doctor Neblett had been on the staff of St. Anthony for 49 years, in addition to serving on the staffs of other hospitals.

ELLIS E. RAIKE, M.D.
Greenup, Ky.
1874-1963

Ellis E. Raike, M.D., 89, retired Greenup general practitioner, died November 2 at the Old Masons Home in Shelbyville, where he had been a patient for four years. Doctor Raike graduated in 1904 from the Kentucky School of Medicine in Louisville.

JOHN C. HALL, M.D.
Ashland, Ky.
1875-1963

John C. Hall, M.D., 88, Ashland general practitioner for many years, died Friday, October 18. Doctor Hall, who was semi-retired from his practice, was a 1904 graduate of the Kentucky School of Medicine in Louisville.

BALLARD F. ROBBINS, M.D.
Berea, Ky.
1907-1963

Ballard F. Robbins, M.D., 56, Berea general practitioner, died November 4 at his home following a heart attack. A native of Tennessee, Doctor Robbins was a 1936 graduate of the Vanderbilt University School of Medicine. He was a veteran of World War II.

S. T. SCRIVNER, M.D.
Stanton, Ky.
1885-1963

Samuel T. Scrivner, M.D., 78, Stanton, died October 30 in Lexington. A native of Estill County, Doctor Scrivner had practiced medicine at Stanton for the past 25 years. He was a director of the Powell and Clark County health departments and was a former Menifee County health officer. Doctor Scrivner was a 1912 graduate of the Medical Department of the University of Louisville.

GROVER C. MEECE, M.D.
Whitley City, Ky.
1893-1963

Grover C. Meece, M.D., 70, who had practiced general medicine at Whitley City since 1928, died October 16 at Hot Springs, Ark. A civic leader in his community, Doctor Meece was honored in 1962 at the dedication of the McCreary County Health Building. He was a graduate of the Kansas City University of Physicians and Surgeons in 1928.

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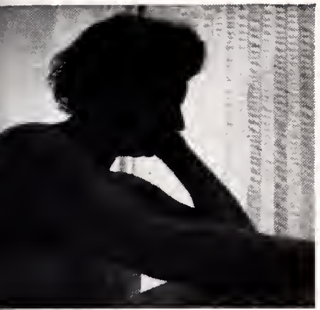
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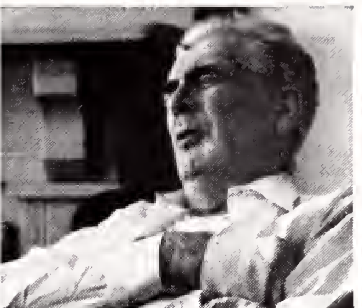
The tense, nervous patient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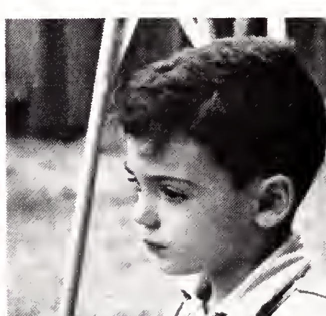
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We must consider drug safety, not as an after-thought to tragedy, but as an integral element of our scientific advance. We must be carefully safe, but we can never be absolutely safe. There is some risk attendant on the acquisition of new knowledge and its application. To me, the future calls for a greater emphasis on the ways and means whereby the results of our enormous investment in health research can be applied for the betterment of mandkind. The counterparts of insulin, pamaquine, digitalis, or even common salt in babies' formulas can be dangerous if improperly used.—Lowell T. Coggeshall, M.D., to Division of Medical sciences, National Academy of Sciences-National Research Council, April 9, 1963.

When the physician observes a significant reaction to a drug, he should inform the Council on Drugs of the American Medical Association, which keeps records of untoward reactions and makes reports periodically. He should also inform the manufacturer, who can watch for reports of similar reactions, warn physicians to modify the dose or method of administration, or withdraw the drug from the market if necessary. In addition, the Federal Food and Drug Administration can be notified since they have the power to remove a toxic drug from the market. In the final analysis, it is the practicing physician who must make the decision whether or not to use a new drug on the particular patient.—Harry F. Dowling, M.D., in *J.A.M.A.*, July 27, 1963.

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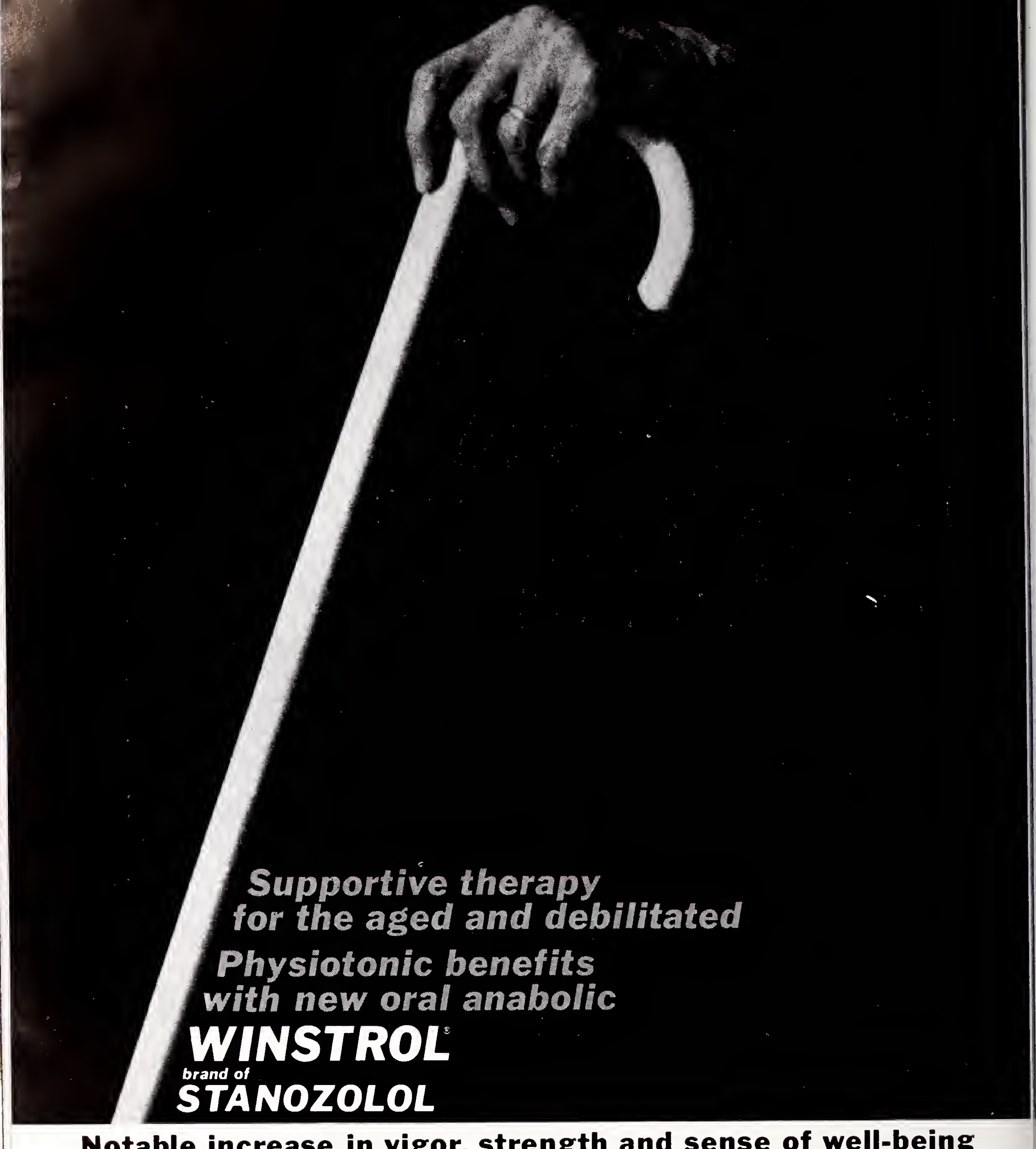

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1963 CONSTITUTION AND BYLAWS OF THE KENTUCKY STATE MEDICAL ASSOCIATION

Revised September 25, 1963

CONSTITUTION

Article I.	Name of the Association
Article II.	Purpose of the Association
Article III.	Component Societies
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Article VIII.	Board of Trustees
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Article I. Name of Association

The name and title of this organization shall be the Kentucky State Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

Article V. Officers

Section 1. The officers of this Association shall be a President, a President-elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee from each District that may be established, and such other officers as may be provided for in the bylaws.

Section 2. The duties and terms of office of all officers of the Association shall be as prescribed in the bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the bylaws.

Section 2. Delegates shall be members of and elected by component societies in such manner as may be provided in the bylaws. Officers of the Association, Delegates and Alternate Delegates to the American Medical Association, and the five immediate Past Presidents shall be ex officio members of the House of Delegates and entitled to vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable. Provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select, including but not limited to an equal per capita assessment by class of membership, upon each component county society. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written

petition signed by not less than 10% of the active membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

BYLAWS

Chapter I.	Membership
Chapter II.	Annual and Special Meetings of the Association
Chapter III.	The House of Delegates
Chapter IV.	Election of Officers
Chapter V.	Duties of Officers
Chapter VI.	Board of Trustees
Chapter VII.	Standing Committees and Councils
Chapter VIII.	Assessments and Expenditures
Chapter IX.	Rules of Conduct
Chapter X.	Rules of Order
Chapter XI.	County Societies
Chapter XII.	Amendments

CHAPTER I. MEMBERSHIP

Section 1. A member of this Association must also be a member of one of the component societies and when certified to the Secretary of the Association as a member of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KSMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship.

Section 2. Membership in the Association shall be divided into seven classes, to-wit: Active, Emeritus, Associate, Inactive, Student, Honorary and Special.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component county medical societies. To be eligible for active membership in any component county society, the applicant must be a doctor of medicine of good moral, ethical, and professional standing, who is licensed to practice medicine in Kentucky.

(b) Emeritus Members. Component societies may elect as a member-emeritus any doctor of medicine who is 70 years of age or who has retired from active practice and who has previously maintained active membership in good standing in his own society for twenty years or more. Emeritus members shall have the right to vote but shall not pay dues, hold office or be entitled to the benefits of Chapter VI, Section 9 of these Bylaws. They shall receive the Journal and other publications of the Association.

(c) Associate Members. The associate membership of the Association shall consist of the associate members of the various component county medical societies. To be eligible for associate membership in any component county society, the applicant must be ineligible for active membership and qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

(2) Interns, residents or teaching fellows who are doctors of medicine and who have complied with all pertinent regulations of the State Board of Health.

Associate members shall not have the right to vote nor to hold office, but shall receive the Journal and other publications of the Association.

(d) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive the Journal and other publications of the Association.

(e) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. Student members shall receive the Journal of the Association. The membership year for student members shall run from September 1 to August 31 of each year.

(f) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(g) Special Members. Component societies may invite dentists, pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded

the privilege of attending and participating in the scientific meetings of the society. Provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

Section 3. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

Section 4. Except as provided in Chapter VI, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association, shall be entitled to any of the rights or benefits of membership in this Association.

CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

Section 1. The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

Section 2. The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or one of the vice presidents. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Section 3. The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

Section 4. Each member in attendance at any meeting shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

Section 2. The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of delegates representing fifty or more component societies. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

Section 3. When a special session is called, the Secretary shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

Section 4. The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

Section 5. In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active members of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

Section 6. Forty per cent of the qualified delegates, as defined by Article VI of the Constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

Section 7. Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary following its introduction. If the author be an individual member, it shall be signed by him. If the author be a group of members, it shall be signed by the authorized spokesman for that group. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 8. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Section 9. The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

Section 10. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse information in relation thereto.

Section 11. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 12. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 13. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 14. It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

Section 15. The state shall be divided into the following districts:

No. 1.—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8—Boone, Campbell, and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10—Fayette, Jessamine, and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurel, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

Section 16. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 17. Except as provided in Chapter VI, Section 5, it shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 18. A digest of proceedings of the House of Delegates shall be published in the Journal of the Association.

CHAPTER IV. ELECTION OF OFFICERS

Section 1. The President-Elect and the Vice Presidents shall be elected for a term of one year. The Speaker of the House of Delegates, the Vice-Speaker of the House, the Secretary and the Treasurer shall be elected for terms of three years. The Trustees shall be elected for terms of three years and shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice President, Speaker or Vice Speaker of the House of Delegates, or Trustees, who has not been an active member of the Association for at least five years.

Section 2. During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as chairman at an organization meeting held during the Interim Meeting, or at some other appropriate place designated by the Board of Trustees at least four months before the Annual Meeting. The Committee, in addition to such other meetings as it may choose to hold, shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the Committee shall have a hearing. Before noon of the following day, the Committee shall post a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nominations for each office to be filled, and shall formally present said nominations to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussions or comment.

Section 3. The election of officers shall be held at the second meeting of the regular session of the House of Delegates.

Section 4. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect. Provided, however, that when there are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

Section 5. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of the Association shall be ineligible for any office for two years.

Section 6. The Delegates representing the counties in each District shall form the Nominating Committee for the purpose of nominating a Trustee for the District concerned. This committee shall hold a well publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting, for the purpose of discussing the nomination for the Trustee to serve the District. Additional nominations may be made from the floor when the Nominating Committee makes its report to the House of Delegates.

CHAPTER V. DUTIES OF OFFICERS

Section 1. Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President, in an amount not to exceed the total amount appropriated for that purpose in the annual budget.

Section 2. The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

Section 3. The Vice Presidents shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice President from the district from which the President was elected shall succeed to the office of the President.

Section 4. The President-Elect and the Vice Presidents, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties, in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses of the President.

Section 5. The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a

non-voting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

Section 6. The Vice Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

Section 7. The Secretary shall advise the Executive Secretary in all secretarial matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and in the event of the death, resignation or removal of the Executive Secretary, shall assume the duties of that office until the vacancy is filled.

Section 8. The Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or the Executive Secretary and shall be countersigned by the Treasurer of the Association. Under unusual circumstances, when one or more of the above-named officials are not readily available, the President or the Chairman of the Board of Trustees is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Board of Trustees. The Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.

CHAPTER VI. BOARD OF TRUSTEES

Section 1. The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the three Vice Presidents, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary, the Treasurer, and the Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the President-Elect, the Secretary, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, to-wit, 14, and a majority of the full Executive Committee, to-wit, 4, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all of the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Section 2. The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

Section 3. Each Trustee shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the existing component societies and their members. He shall likewise hold at least one district meeting each year in order to afford a forum for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Treasurer upon a proper itemized statement, but this shall not be construed to include his expenses in attending the Annual Meeting of the Association.

Section 4. Collectively the Board shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Board without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the Constitution, By-laws, or rule or regulation of this Association, or the Principles of Ethics of the American Medical Association, shall be liable to censure, suspension or expulsion.

No disciplinary decision of an individual Trustee or District Grievance Committee shall become effective unless and until approved by the Board of Trustees, and where an appeal from such decision is taken by the respondent member, the Board may admit such oral or written evidence as in its judgment will best and most fairly present the facts.

It may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be heard on the record made before the component society, in the manner provided in Chapter XI, Section 10 of these Bylaws.

Efforts toward conciliation and compromise shall precede the hearing of disciplinary cases, but the decision of the Board of Trustees in all such cases shall be final.

Section 5. The Board shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press. Such communications shall be signed by the President of the Association and the Chairman of the Board.

Section 6. The Journal of the Kentucky State Medical Association shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the Journal shall be elected by the Board. All money received by the Journal or by any member of its staff on its behalf, shall be paid to the Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 7. All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

Section 8. In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the President may call a meeting of the delegates of record from the counties

of that district for the purpose of submitting one or more nominees as candidates to fill the office until the Trustee's disability is removed or until the next meeting of the House of Delegates. The name or names of the nominee or nominees shall be submitted to the Board, which may elect an acting Trustee from them.

Section 9. The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

Section 10. The Board shall employ an Executive Secretary whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Secretary shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Treasurer. He shall within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a card index register of all practitioners in the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor of the Journal of the Kentucky State Medical Association under supervision of the Board and in a similar capacity to the extent that other publications are authorized by the House of Delegates.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

CHAPTER VII. STANDING COMMITTEES AND COUNCILS

Section 1. The Board of Trustees shall, upon nomination of its Executive Committee, appoint and designate the chairmen of five standing committees composed of not less than five nor more than seven members, as follows:

(a) A Committee to Study the Constitution and Bylaws
(b) A Committee on Third-Party Medicine
(c) A Committee on Professional Relations
(d) A Committee on Arrangements for the Interim Meeting.
(e) An Advisory Committee to the Editor of the Journal

Section 2. The Board of Trustees shall, in the same manner, (except as hereinafter provided) appoint and designate the chairmen of six Councils, composed of not less than five nor more than seven members, as follows:

(a) A Council on Scientific Assembly.
(b) A Council on Medical Education and Hospitals.
(c) A Council on Legislative Activities.
(d) A Council on Medical Services.
(e) A Council on Communications and Public Service.
(f) A Council on Allied Professions and Related Groups.

Section 3. The Executive Committee shall serve as the nominating committee for all Standing Committee and Council appointments, but the Trustees may make additional nominations from the floor. When the Executive Committee sits as such nominating committee, the President shall serve as Chairman.

Section 4. Except as otherwise provided herein, members of Standing Committees and Councils shall be appointed for terms of not less than one year and of not more than three years, and until their successors are appointed. Each committee and council (other than the Council on Scientific Assembly) shall meet and organize as soon after its appointment as possible, and shall meet again near the close of the associational year, for the purpose of formulating its annual report. It may meet at such other times as may be necessary or desirable. The Headquarters Office shall be the headquarters for all Committees and Councils, unless otherwise specifically ordered by the Board of Trustees or its Executive Committee.

Five-member Committees and Councils shall have a quorum of three, and seven-member Committees and Councils shall have a quorum of four members present before any business other than the fixing of the time and place of the next meeting, may be transacted.

All committees, other than standing committees, shall be assigned to a council and shall report their activities and recommendations *only* to the council to which assigned. These reports will be reviewed by the various councils and no such reports or recommendations will be considered by the Board of Trustees unless and until reviewed by the proper council.

Each Standing Committee and Council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted, without alteration or amendment, to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. Committees and Councils may submit supplemental reports if such reports are in the hands of the Secretary at least 48 hours in advance of the first meeting of the Regular Session of the House of Delegates.

Section 5. The President, Secretary, and Executive Secretary shall be ex officio members of all Commit-

tees and Councils, without power to vote except as otherwise specified herein.

Section 6. The Board of Trustees shall have power to establish such other committees as may, from time to time, appear to it to be advisable, and to prescribe their composition, the method of their appointment, and their duties. Such committees shall serve at the pleasure of the Board.

In addition, the Board of Trustees shall have power to appoint a representative from this Association to the Conference of Presidents and such other organizations as it shall determine.

Section 7. The Committee to Study the Constitution and Bylaws shall make a continuing study of the Constitution and Bylaws and shall annually recommend such revisions of either or both of these documents as changing times and conditions indicate.

Section 8. The Committee on Third Party Medicine shall make a continuing study of Third Party Medicine, and shall maintain liaison with all medical care plans which employ physicians on a salaried basis in this state. It shall mediate disputes between members and such plans, and shall continually strive to persuade such plans to shape their relations with their employed physicians and with the public, in conformity to the views of this Association.

Section 9. The Professional Relations Committee shall supervise and coordinate the work of the various District Grievance Committees hereinafter created. The Trustee of each District is hereby designated the Chairman of his District Grievance Committee. The Professional Relations Committee shall designate two (2) additional Trustees from Districts adjoining that of the Chairman, and the three Trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual Trustees, shall be referred to the District Grievance Committee for the District in which the respondent physician or county society resides. If requested to do so, the District Grievance Committee shall hold hearings and hear evidence and render a decision based upon the evidence thus presented. Any party aggrieved by the decision of the District Grievance Committee, shall have the right to appeal to the Board of Trustees in the manner provided by Section 4 of Chapter VI of these Bylaws.

All grievances, whether handled by individual Trustees or by District Grievance Committees, shall be reported to the Professional Relations Committee, which shall include in its report to the Board of Trustees, a statistical resume of the number of cases handled and the disposition thereof. In addition, the Professional Relations Committee shall make recommendations to the Board of Trustees with respect to any course of action which the Committee determines to be desirable, in the light of its experience during the year covered by its report.

Section 10. The Committee on Arrangements for the Interim Meeting shall have the responsibility of preparing the program for the Interim Meeting, and presenting it to the Board of Trustees or its Executive Committee for approval. Upon approval of the program thus presented, the Committee shall have the further responsibility of approving all arrangements for the Conference.

Section 11. The Advisory Committee to the Editor of the Journal shall provide support to the Editor and be available to him for consultation with respect to any matter concerning the Journal, on which he desires the Committee's advice and assistance. All papers of doubtful suitability for publication shall be referred by the Editor to the Advisory Committee, and its approval shall be required prior to the publication of any matter which is recognized to be of a controversial nature.

Section 12. The Council on Scientific Assembly shall consist of seven (7) members. The President, the President-Elect, and the chairmen of the Committees on Scientific and Technical Exhibits shall, by virtue of their respective offices, be voting members of the Council, with the President serving as Chairman and the President-Elect as Vice-Chairman. The remaining three members shall serve for terms of three (3) years each, with the term of one member expiring each year. The Council shall supervise and direct the planning, development and presentation of the scientific programs of the Annual Meeting each year. In addition, it shall be responsible for scientific and technical exhibits and all activities incident to the Annual Meeting, including golf and other forms of recreation and entertainment. These will include the duties heretofore imposed upon the Awards Committee to nominate the recipients of the Distinguished Service Medal, the Outstanding General Practitioner Award, and the R. Haynes Barr Award.

Thirty (30) days previous to each Annual Meeting, the Council shall prepare and issue a program announcing the order in which papers, discussions, and other business shall be presented, which program shall be adhered to as nearly as practicable. No county society, as such, shall serve as host society to the Annual Meeting.

Section 13. The Council on Medical Education and Hospitals shall direct and supervise the activities of the Association in the field of medical education, and shall maintain active liaison with the Kentucky Hospital Association. It shall seek to elevate the standards of postgraduate medical education in Kentucky, establishing and maintaining liaison with Kentucky's two medical schools and the Committee for the American Medical Education Foundation, and concerning itself with problems relating to medical and hospital care, general practice, and such other matters in this general field as may be referred to it by the Board.

Section 14. The Council on Legislative Activities shall direct and supervise the work of the Association as it pertains to state and national legislation, and shall formulate and submit a legislative program to the Board of Trustees for its consideration. The Council shall seek the enactment of the Association's legislative program into law, and shall resist the enactment of bills which the Board finds to be not in the best interests of the public or the profession. It shall maintain liaison with officials of state and national governments and shall work closely with the various county societies in carrying out the legislative program at both state and national levels.

Section 15. The Council on Medical Services shall supervise and direct the activities of the Association in the field of socio-economic development. It shall be charged with the promotion of voluntary health insurance programs in general and shall maintain active liaison with Kentucky Physicians Mutual, Inc., and Blue Cross plans. It shall advise on medical service contracts with the state and federal governments and shall serve as a clearing house on all fee schedules and other questions affecting the economics of medicine. It shall concern itself with the problem of providing adequate medical care for the aged, and shall maintain careful scrutiny of all state or national programs which purport to deal with this problem.

Section 16. The Council on Communications and Public Service shall supervise and direct all associational activity in the fields of public relations and service, including, but not limited to, rural health, schools, public health, emergency medical services and diabetes.

Section 17. The Council on Allied Professions and Related Groups shall concern itself with the development and promotion of improved health standards and shall establish and maintain liaison with the dental, nursing and pharmacy professions in this state. It shall supervise and direct the Association's activities in the fields of infant and maternal mortality, physical medicine and rehabilitation, industrial medicine, tuberculosis, blood banks and other related subjects, and shall interest itself in the work of voluntary health associations.

CHAPTER VIII. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Members, $75, except Active Members who devote all of their time to teaching or research and have no private practice, $50.00; (2) Emeritus Members, no dues; (3) Associate Members, $8; (4) Inactive Members, $8; (5) Student Members, $1; (6) Honorary Members, no dues; (7) Special Members, no dues. Dues fixed by these Bylaws shall constitute assessments against the component societies. The Secretary of each component society shall forward its assessment together with its roster of all officers and members, list of delegates and list of non-affiliated physicians of the county to the Secretary of this Association as of the first day of January in each year.

Section 2. Any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective.

CHAPTER IX. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

CHAPTER X. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

CHAPTER XI. COUNTY SOCIETIES

Section 1. Except as provided in Section 4 of this Chapter, all county medical societies in this state which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary. The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 4. Only one component society shall be chartered in any county except that the House of Delegates may issue a charter to one statewide society of worthy Negro physicians who are not members of any component society. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky State Medical Association.

Section 5. In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Section 6. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky State Medical Association, and shall be classified in accordance with Chapter I, Section 2 of these Bylaws. Provided, however, that no physician who is under suspension or who has been expelled by the Board of Trustees shall thereafter, without reinstatement by said Board, be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 7 and/or 9 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

Section 7. Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides. (Disciplinary procedures are governed by Section 4, Chapter VI of these Bylaws.)

Section 8. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 9. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

Section 10. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days appeal to the Board of Trustees, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Board of Trustees to those portions of the transcript upon which he relies.

Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership. Provided, however, that an appeal shall stay the suspension until a final decision is made by the Board of Trustees.

The resignation of a member against whom dis-

ciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees.

Section 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

Section 12. At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session. Provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 members in good standing, plus one delegate for one or more members in excess of multiples of 25. Provided, however that each component society shall be entitled to at least one delegate regardless of the number of members it may have and the secretary of the society shall send a list of such delegates to the Secretary of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KSMA Headquarters Office with a certified list of its delegates each year.

Section 13. The secretary of each component society shall keep a roster of its members and a list of non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary of the Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 14. The secretary of each component society shall report to the Journal of the Kentucky State Medical Association full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

CHAPTER XII. AMENDMENTS

These Bylaws may be amended at any session of the House of Delegates by a two-thirds vote of all the delegates present at that session, after the amendment has laid on the table for one day.

Mark Your Calendar Now

To Attend the

1964 KSMA Interim Meeting

at

Jenny Wiley State Park

Prestonsburg, Ky. **April 23, 1963**

WASHINGTON NEWS DIGEST

WASHINGTON, D.C. — President Kennedy signed into law two bills providing for a five-year, $594.2 million federal program to combat mental illness and mental retardation through expanded research and community treatment centers.

A key feature of the legislation is a $150 million program of grants to the states for construction of community mental health centers for inpatient and outpatient treatment of the mentally ill. Administration officials said they hoped that such centers eventually would be able to take care of as much as 50 percent of the mentally ill persons now in state mental institutions. One aim of the centers is to have the family physician play a larger role in the treatment of the mentally ill.

The new law contains no authority for federal funds for staffing these centers, most controversial aspect of the legislation in congress. The American Medical Association opposed the staffing provision.

In signing the bill, President Kennedy announced that Robert Aldrich, Director of the National Institute of Child Health and Human Development, will soon call together 50 scientists from this country and abroad to plan research on premature births.

He also announced that the office of education was setting up a new division for handicapped children and youth to administer the teaching and research program under the new law. It will be headed by Samuel Kirk, Professor of Education and Psychology at the University of Illinois.

The new law also provides $179 million over three years for construction of treatment and research facilities for the mentally retarded and for training of teachers for mentally retarded children.

Earlier, President Kennedy had signed into law another part of the mental retardation program that was approved in separate legislation by Congress. This calls for $355 million to increase Federal aid in fighting mental retardation through improved maternal and child care. The five-to-seven-year program includes a plan to provide preventative medical care for low-income mothers with a high risk of giving birth to retarded children.

* * * *

The Food and Drug Administration issued the final orders on how it will carry out the new drug law's provisions covering ethical drug advertising. The federal agency agreed to modify most of the proposed regulations that the drug companies had protested.

One previously-disputed section of the regulations was felt by the companies possibly to require the prepublication submission to FDA of advertising for virtually all important new drugs. The FDA revised the regulation to require "prior approval" of advertisements by the FDA only if the agency of the sponsor of the drug receives information not widely publicized in medical literature that use of the drug may cause fatalities or serious damage.

Another issue raised concerned sections of the regulations relating to "fair balance" and "relative prominence" of information on effectiveness and precautions in use of prescription drugs in advertising copy and layouts.

FDA assured the industry that the regulations will not prohibit use of graphic presentations, headlines or other "advertising techniques." The regulations, as now clarified by the agency, will not require equal divisions of space, word counts, headlines, illustrations and so forth. On the other hand, the regulation will require that statements about precautions for use of drugs be presented in type and format to insure adequate prominence and readability.

THE JOURNAL

of the

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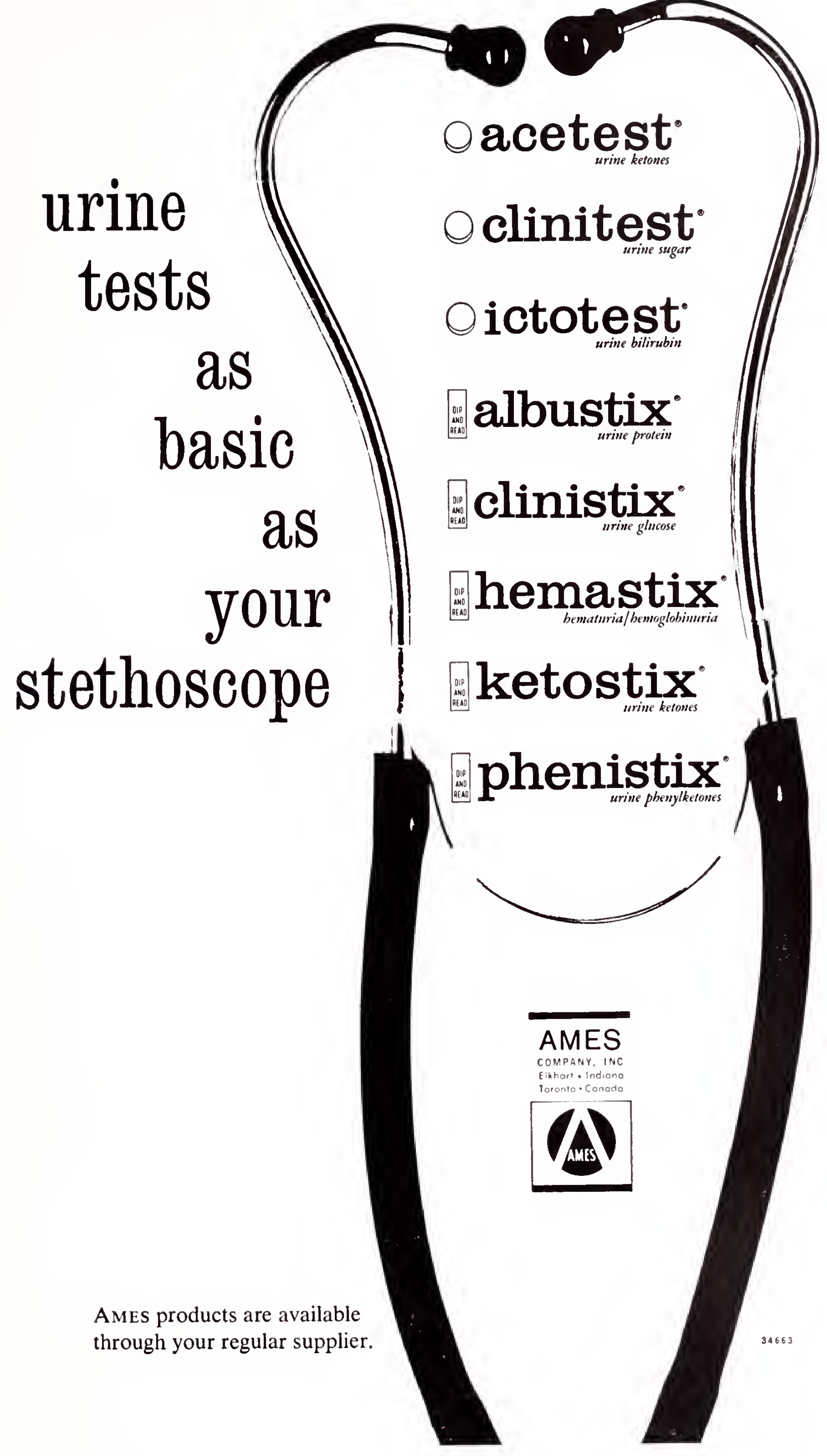

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